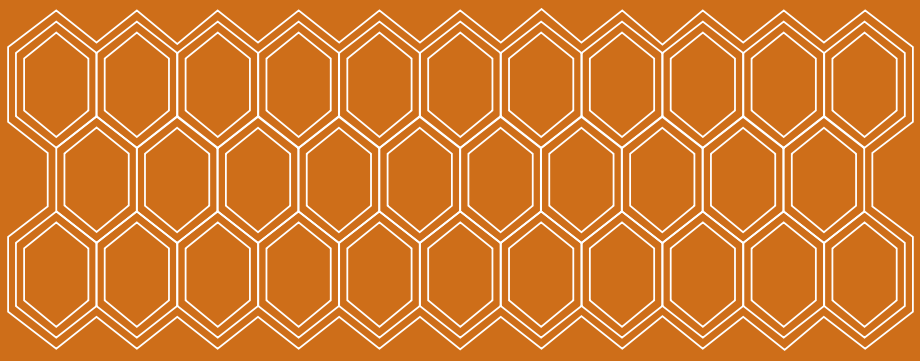

The Yale-China Health Journal

Autumn 2003 Volume 2

Mission

The Yale-China Association is a private, non-profit organization that contributes to the development of education in and about China and the furtherance of knowledge, understanding and friendship between Chinese and American people. Our work is based on the conviction that sustained, one-on-one contacts between Chinese and American people through educational exchange not only enrich the lives of the individuals involved but contribute, ultimately, to more peaceful relations between our two nations. Teaching and learning are at the heart of our work.

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The Yale-China Association was founded in 1901. For its first half-century, Yale-China's work was centered in Changsha and Wuhan, where it helped to found Hsiang-Ya Hospital, Medical College, and Nursing School, the Yali Middle School, and Huachung University. Collaboration with New Asia College, now a part of the Chinese University of Hong Kong, began in 1953, and programs at mainland institutions were resumed in 1980.

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FOREWORD

This second issue of *The Yale-China Health Journal* is devoted exclusively to a multi-faceted discussion of the HIV/AIDS epidemic in China, one of the most daunting health challenges the country will face in the years to come. Taken together, the articles and interviews presented here provide an overview of the epidemiology and complexities of the Chinese epidemic through early 2003, as well as the socioeconomic conditions that will shape its future trajectory. Most contributors presented earlier drafts of their papers on December 7, 2002 at a conference organized by the Yale-China Association entitled "The AIDS Epidemic in China: Points of Vulnerability and Sources of Strength," which also featured presentations by David Ho, MD and Wan Yanhai, MD. We would like to express our appreciation to all of the presenters; to Philip Alcabes and Susan Rhodes, who served as discussants; and to members of the audience for posing provocative questions, highlighting important issues, and contributing to the depth of the ensuing discussion and hence these papers. With publication of this issue of the *Journal* we hope to extend and continue those dialogues, and encourage readers to write to the editors or authors at the Yale-China Association.

Alana Rosenberg and Michael Merson begin by recounting the roots and current scale of the HIV/AIDS crisis, showing that it is not a homogenous epidemic but a constellation of individual epidemics differently affecting specific regions and sub-populations. Next, in a paper outlining the challenges the epidemic presents to the Chinese health care system, Ann B. Williams and Hong Wang suggest that government action will be decisive to achieving an effective response. Here, as in other dimensions, China's situation is not unique: both in

the wealthy nations of Europe and North America and in sub-Saharan Africa, most governments denied the risks of HIV/AIDS for too long and failed to act aggressively to provide prevention and treatment. But in China, there are additional challenges, both because voluntarism through NGOs is still in its infancy and because China's recent effort to privatize and decentralize funding for both curative and preventive medicine weakens its ability to develop an effective continuum of care and implementation of international "best practices." (See also volume one of the *Journal* for an overview of the Chinese health care system.)

Turning to specific demographic sub-groups that have been most severely affected by the epidemic, Kaveh Khoshnood and Stephanie Weber examine the complexities of the epidemic among drug users, who currently represent the largest group of HIV-infected individuals in China, and summarize international best practices that could reduce the risk and consequences of infection among this population. Elanah Uretsky draws readers' attention to culturally grounded notions of male sexuality and masculinity, illustrating how locally-defined gender roles influence HIV transmission and arguing that successful prevention programs therefore must look beyond changing individual behavior among traditional "high risk groups" to changing the social framework that places these populations at risk.

Highlighting similar themes of socially constructed norms of gender and sexuality, Robert Geyer explores the vulnerability to HIV/AIDS of Chinese men who have sex with men, emphasizing the ambivalence of most men about acknowledging this behavior or "coming-out," as well as the impact of the social expectation that all men will marry. Drawing on ethnographic research in one of the epicenters of the epidemic in Yunnan, Sandra Hyde discusses the transmission of HIV/AIDS among commercial sex workers, including the role of socioeconomic changes in facilitating the rapid spread of HIV among this vulnerable population. Joan Kaufman then examines the broader issue of reproductive health policy and programs, calling for a closer integration of HIV prevention and treatment with reproductive health and family planning services and programs.

Finally, interviews with Wan Yanhai and Jonathan Hecht return to questions about the role of government agencies and the law during a period in which Chinese society is becoming ever more integrated with the rest of the world via the Internet, global trade, and membership in international organizations. Wan, founder of one of the few Chinese NGOs devoted to HIV/AIDS education, sees great potential for grass roots activism, but identifies many constraints on effective partnerships between small community organizations and the large government bureaucracies that dominate health care. As a result, Wan continues to advo-

cate for new strategies to mobilize the resources of the Chinese government.

Hecht addresses a range of legal concerns and also notes several issues that are somewhat particular to China. First, the Chinese Constitution guarantees the right to health care, and even when reality falls short of the promise, ideologically the government is committed to universal care. Another noteworthy legal issue is the way in which Chinese law views sex workers, homosexuals, and drug addicts as individuals involved in illegal rather than criminal acts. Hecht notes that punishment can be as severe for illegal as for criminal activities, but that the distinction may provide more emphasis on education and treatment and thereby shape the Chinese government's interventions against the spread of HIV/AIDS in ways that we have not seen elsewhere. Among those who became infected through the blood collection centers, Hecht also sees a possibility that a new awareness of legal rights may spur claims for compensation as well as care and nondiscrimination. But in the short term, Hecht finds individuals in a weak bargaining position vis-à-vis the government and, like Wan, identifies central government ministries and bureaucrats as the key actors.

* * *

The Yale-China Association's interest and involvement in the field of HIV/AIDS dates to 1996, when Ann B. Williams delivered her first lecture on the world-wide pandemic to nursing students and faculty at Yale-China's long-time institutional partner, the Xiangya School of Medicine, in Changsha, Hunan. At the time, HIV/AIDS was viewed by most Chinese as an exotic disease primarily affecting foreigners. With the exceptions of two nurses who had studied in Thailand and spoke movingly of what they had witnessed there, most people in the audience expressed little interest and believed that HIV/AIDS would never become a Chinese problem. In the years since that 1996 lecture, HIV has tragically continued its deadly march, infecting vulnerable populations in every province in China and frequently spreading fear and stigma among both the general public and the health care workforce.

Yale-China's efforts to address the AIDS crisis have focused on preparing nurses, who have been on the front lines of the epidemic wherever it has hit in force, to provide care and to educate patients and their families. In 1997, with support from the World AIDS Foundation and in collaboration with the Xiangya School of Medicine, Yale-China began a series of HIV/AIDS train-the-trainer workshops. That curriculum now serves as the basis for a national program launched last year in partnership with the Beijing-based National Nursing

Center of China. In 2003 and 2004, train-the-trainer workshops will reach as many as 20,000 nurses in four of the hardest hit provinces—Guangdong, Sichuan, Xinjiang and Yunnan. The need for such training is acutely felt by nurses, especially those who have been caring for HIV/AIDS patients but in many cases have never received any AIDS-related training. Our program has thus been well received by participants, government agencies, non-governmental organizations, and international agencies alike.

The ranks of those engaged in HIV/AIDS work in China are thin but growing. It is our hope therefore that in advancing knowledge among those best positioned to mount an effective response, it will be possible for China to benefit from the experience and avoid the mistakes of other countries affected earlier by the disease, thereby lessening the toll of human pain and suffering.

—The Editors

The Challenges of HIV/AIDS in China: An Overview

Alana Rosenberg and Michael Merson

This is a critical time in the HIV/AIDS epidemic in China, as numbers of infections and cases increase and the government seems more willing to recognize the problem and mount an effective response. On a visit to China in October 2002, United Nations Secretary General Kofi Annan urgently appealed to the Chinese people and the international community to respond immediately. He spoke about the social and economic havoc that AIDS could reap in the country, and how the course of the epidemic in China during the next few years would affect the global pandemic. He urged political leaders to convey to Chinese citizens that AIDS is "a problem with a solution" (Kaiser Network, 2002). Indeed, the extent to which China can embody this realistic, proactive approach in its policies and practices will determine its success in curbing the epidemic.

This paper will present an overview of the HIV/AIDS epidemic in China. It will describe the spread of HIV through intravenous drug use, blood donation, and heterosexual transmission; discuss the structural factors contributing to the vulnerability of high-risk groups and the general public, many of which are related to China's recent socioeconomic transition; and review the key components and strategies that comprise an effective response. Many of the ideas introduced here will be explored more fully in the essays that follow.

Epidemiological Situation

The first AIDS diagnosis was made in China in 1985. Between 1985 and 1988, often termed the first phase of China's epidemic, there were a small number of cases reported in coastal cities, mainly among foreigners and overseas Chinese.

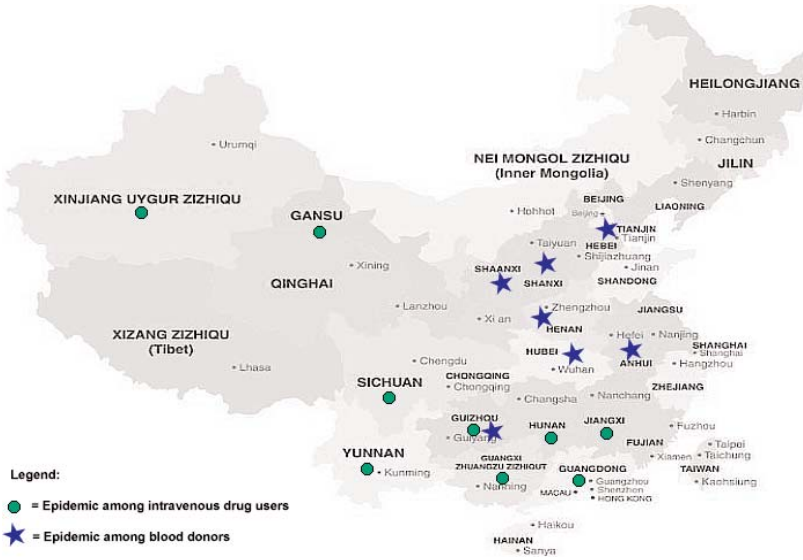
The second phase of the epidemic, which began in 1989 and ended in 1993, was characterized by an epidemic among injecting drug users (IDUs) belonging to minority communities in Yunnan province, which borders Laos, Myanmar and Vietnam in southwest China. The third and current phase of the epidemic began in 1994, with a significant increase in the number of new infections, primarily among drug users and blood donors. By 1998, HIV had been reported in each of China's 31 provinces, autonomous regions, and municipalities (Zhang, K., 2002).

UNAIDS, in its 2001 update of the global AIDS situation, reported that there were between 800,000 and 1.5 million HIV-infected persons in China. Officially, the number of reported new HIV infections rose about 17% in the first half of 2002 (UNAIDS, 2002). In July 2002, the Chinese government announced that an estimated 850,000 persons were infected, but in September, this estimate was raised to one million. A United States National Intelligence Council report published in September 2002 estimated that there were one to two million HIV-infected Chinese, or between .13% and .25% of the adult population (National Intelligence Council, 2002). Estimates of HIV infection rates are derived from the national and provincial sentinel surveillance systems, which collect HIV prevalence data twice a year from patients with sexually transmitted diseases, commercial sex workers, IDUs, truck drivers, and pregnant women. In 2000, 50,000 tests were conducted at 101 sentinel sites in 31 provincial-level units (UN Theme Group, 2002). This system needs to be improved, but is the most accurate data source available and serves as the current foundation for projections of the epidemic.

The exact distribution of HIV infections related to needle-sharing among IDUs, unsafe blood collection, and sexual transmission remains difficult to discern. The most frequent reported mode of HIV transmission in China to date is needle-sharing among IDUs: UNAIDS reported that it accounted for about two-thirds of reported new HIV infections in 2001, though this percentage may be elevated due to more frequent testing of the IDU population versus other groups (UNAIDS, 2002). Paid blood collection is the second most frequent mode of transmission. While the HIV transmission rate through this mode is unknown, estimates of the total number of people infected through unsafe blood collection range from 30,000 to two million in Henan province alone (Trager, 2002). Figure 1 shows the provinces affected by both IDU and blood collection epidemics. Finally, sexual transmission accounts for a small but rising percentage of all reported HIV infections. One estimate of the heterosexual transmission rate is about 7% (Zhang, K., 2002). Homosexual transmission undoubtedly occurs,

but HIV prevalence among men who have sex with men is unknown as this population is largely hidden.

FIGURE 1: IDU AND BLOOD DONOR EPIDEMICS



The National Intelligence Council's report mentioned above warned that much of the increase in HIV infections globally during this decade will be due to the growth of the epidemic in five populous countries: Nigeria, Ethiopia, Russia, China and India. The report estimates that by 2010, 10–15 million Chinese will be infected, making the adult prevalence rate 1.3% to 2%. This means that China, along with India, is likely to contain the largest number of people with HIV/AIDS compared to all other countries worldwide by the year 2010. UNAIDS estimates this number to be even higher, at 20 million, while the Chinese government conservatively estimates 6.4 million persons infected by the end of the decade (Eberstadt, 2002).

Injecting Drug Users

Drug use is on the rise in China. Heroin and, to a lesser extent, opium are the most frequently used drugs in China today (see Khoshnood paper in this issue). Economic hardship due to the country's recent socioeconomic transition has

undoubtedly contributed to drug use increase among marginalized groups. Demographics may also play a part: one hypothesis for the increase in drug use among middle and upper class urban youth holds that families often indulge adolescents due to the one-child policy, providing them the means necessary to experiment with drugs (Gill, Chang, & Palmer, 2002). In 2001, there were over 900,000 registered drug users in China, said by international experts to be an underestimate (Zhang, K., 2002). The number of drug users who inject is also increasing, as it is perceived to be a less expensive way to get high. Intake questionnaires at rehabilitation centers show that over 50% of IDUs share equipment (UNAIDS, 2002). One implication of IDUs being the main group of HIV-infected in China currently is the likely misperception among the general population that non-drug users are less vulnerable to infection (Gill et al., 2002).

TABLE 1: PROVINCES AND SITES WITH HIGHEST HIV INFECTION RATES AMONG IDUS

Provinces	Sites and Rates			
Xinjiang (2000)	Yining 84%		Urumqi 39%	
Yunnan (2000)	Ruili >80%	Wenshen 75%	Kaiyuan 58%	Yingjiang 70%
Guangdong (2000)	Sentinel site: 21%			
Guangxi (2000)	Baise 30–40%	Pingxiang 12%	Liuzhou 12%	
Jiangxi (2000)	Sentinel site: 17%			
Hunan (2002)	Sentinel site: 8%			
Guizhou (2002)	Sentinel site: 14%			

Source: The U.N. Theme Group on HIV/AIDS in China, "HIV/AIDS: China's Titanic Peril," June 2002, and UNAIDS, "AIDS Epidemic Update," December 2002.

Nine provinces have serious epidemics among IDUs (UNAIDS, 2002), infection rates for seven of which appear in Table 1. Many of these are in the southwest, bordering the drug-producing Golden Triangle countries of Myanmar, Laos, and Thailand, and those on the drug trafficking route north through China. In Yunnan, HIV infections are now found throughout the province, and infection rates among resident IDUs in many cities are often above 50% and as high as 80%. The Guangxi Zhuang Autonomous Region, bordering Yunnan, is experiencing an alarming epidemic among resident drug users, with 87% of them injecting, and more than half sharing needles. Also on the southern border, in Guangdong province, where the epidemic began among IDUs in 1998, the highest prevalence is found in the capital city of Guangzhou, where 20% of IDUs tested at sentinel sites were HIV-positive in 2000. In Sichuan, HIV

infection has been increasing since 1996 among IDUs of the Yi minority in Liangshan prefecture, located along a major drug trafficking route from Myanmar through China. The Xinjiang Uygur Autonomous Region in the northwest faced a marked increase in injection among drug users in 1996, and a corresponding HIV epidemic among IDUs. In Yili prefecture, 9% of IDUs tested positive in January of that year. By August, the percentage had increased to 76%. Gansu and Jiangxi provinces' epidemics are relatively recent, beginning in 1999 and 2000, respectively. UNAIDS reports that the epidemic in Jiangxi, where 45 HIV cases were reported in 2000, might have been preventable, as high rates of needle-sharing had been reported earlier and intensive harm reduction measures might have been effective (UNAIDS, 2002). The most recent outbreaks are in Hunan, where HIV prevalence among IDUs is 8% and Guizhou, where it is 14% (UNAIDS, 2002).

Blood Donors

The HIV epidemic in Henan, China's second most populous province with close to 100 million people, has been most severely affected by unsafe blood collection practices begun during the mid-1990s, as recently exposed by the Chinese and international press. According to these reports, illegal, commercial blood processing companies paid poor farmers, with annual incomes of 1600 to 2400 yuan ($200–300), between 40 and 100 yuan ($5–12) for their blood. Blood from multiple donors was then pooled, the plasma separated and sold presumably to health facilities for transfusion purposes, and the remaining blood cells and platelets reinjected back into the donors, making it possible to infect dozens with HIV. Blood donors reported selling their blood as much as three times a day, five days at a time, sometimes over the course of months or years. Syringes were reused and sellers were rarely screened for HIV or other blood-borne diseases. Entire villages sold their blood. In January 2002, residents of one such village of 4000 told journalists from the French newspaper *Liberation* that 80% of adults living there were HIV-positive (Cowhig, 2002). Local officials have tried to conceal their involvement in these practices, making it difficult to assess the full extent of the problem or initiate effective regulation (Gill et al., 2002). A 1998 Blood Donation Law made blood selling illegal, but rather than improve the situation, it pushed transactions underground, making regulation nearly impossible (Gill et al., 2002). The extent to which these collection practices exist today is unknown.

The Beijing Aizhixing Institute of Health Education, a Beijing-based nongovernmental organization whose founders helped to expose the enormity of the epidemic in Henan, reports that in Shangcai county alone, there are 35,000 cases of infection, and an equal number of orphans whose parents have died of

AIDS. Orphan care is becoming an urgent issue in Henan, where both parents were often blood donors or one unknowingly infected his or her spouse through sexual transmission. Similar epidemics related to blood donation have been reported in at least six other provinces, including Hebei, Anhui, Shanxi, Shaanxi, Hubei, and Guizhou (UNAIDS, 2002). The number of persons infected through selling blood and the number infected through receiving plasma transfusions has not been determined, but both modes are likely to be contributing to the spread of HIV.

Sexual Transmission

While most HIV infections in China are currently among IDUs and those affected by unsafe blood collection schemes, sexual transmission is swiftly becoming an important mode of transmission.

According to the Chinese police, there are more than 4 million commercial sex workers (CSWs) in China today (Gill et al., 2002). The sudden increase in HIV-infected sex workers can be seen in Table 2, which illustrates the growing number of infections among this population in Guangxi, Yunnan, and Guangdong. Between the second and fourth quarters of 2000, there was an average increase of almost 2% in the rate of HIV infection among CSWs in these three provinces. Lack of knowledge about HIV, low condom use rates, injecting drug use, and high rates of sexually transmitted disease (STD), as explained below, will contribute to growing HIV rates within the CSW population in the coming years. In the 2000 Ministry of Health Annual Report on sexually transmitted infection/ HIV/AIDS, over 60% of CSWs in nine provinces reported never using condoms, and less than 20% in 12 provinces reported always using condoms (UNAIDS, 2002). CSWs often do not use condoms because they do not know condoms can protect against HIV; those who carry condoms are often arrested by local police; and CSWs often lack the power to refuse sex without condoms. The HIV epidemic in other Asian countries has shown the potential for sex workers and their clients to fuel a generalized epidemic.

TABLE 2: PERCENTAGE OF HIV POSITIVITY AMONG SEX WORKERS IN SELECTED SENTINEL SITES, 2000

Province	Second Quarter	Fourth Quarter
Guangxi	9.9 (N=354)	10.7 (N=394)
Yunnan	1.6 (N=450)	4.6 (N=370)
Guangdong (Guangzhou)	1.2 (N=251)	3.0 (N=336)

Source: The U.N. Theme Group on HIV/AIDS in China, "HIV/AIDS: China's Titanic Peril," June 2002.

A subgroup of the Chinese population at risk for sexual transmission is men who have sex with men. Estimated by some to make up between five and seven percent of the male population (Gill et al., 2002), their vulnerability is compounded by China's lack of tolerance for homosexuality. While officially homosexuals have recently gained more freedom from discrimination, a lack of leadership and collective identity make HIV prevention difficult among this population. The extent to which homosexuality can be openly expressed and tolerated may determine the success of prevention campaigns targeted towards homosexuals. In his paper in this volume, Robert Geyer highlights the deep-seated ambivalence of both the homosexual community and society at large in outwardly recognizing their lifestyle and its implications for the spread of HIV. Many men who have sex with men are married, putting their wives at unknowing risk for HIV as well.

Finally, China's current demographic situation, with more males than females and a large proportion of young people, has implications for the spread of HIV through sexual transmission in the general population. Also of particular importance is China's "floating population," composed of more than 100 million rural-to-urban migrants, and some of the 40 million urban workers laid off from closed government-run businesses (Gill et al., 2002). Because they live outside their official place of residence, they are not eligible for government assistance in housing subsidies, health care, or education. Mainly young and middle-aged, they are often uneducated and sometimes speak only non-Mandarin dialects (Gill et al., 2002). Women comprise up to 40% of the floating population; they are often young, unmarried factory workers. The floating population's migratory and marginalized status makes it difficult for public health efforts to reach them. Men's return home, often during Spring Festival, puts their monogamous "family partner" at unknowing risk for HIV and triggers local epidemics (United Nations Development Program, 2001).

Structural Factors Creating Vulnerability to HIV in China

Institutional denial and lack of some basic human rights and legal protection make essential resources important for HIV prevention unavailable to many people. These include accurate information about HIV, condoms, and a rights-based approach to testing and to social and legal protection of People Living with AIDS (PLWA). There have not been any national HIV/AIDS awareness campaigns in the country to date, resulting in a widespread lack of knowledge about HIV/AIDS. In 1999, a reproductive health survey of more than 30,000 Chinese women showed that nearly 55% of illiterate or semi-literate women had never heard of AIDS (UNAIDS, 2002). A study published in 1999 showed that 88% of

1,148 people in Neijiang, Sichuan province preferred that PLWAs not have social interaction with other people (UNAIDS, 2002). A survey undertaken by the State Family Planning Commission, published in December 2000, measured the knowledge, attitudes and practices of 529 people of reproductive age in six provinces. Only 17% were aware that blood transfusions could transmit HIV, 11% knew that condoms could protect against HIV, and 10% knew a needle was only safe if sterile (UNAIDS, 2002). In a study conducted in early 2002, two-thirds of 2,062 middle school students in Beijing thought mosquitoes transmit HIV, 40% did not know that it can be spread by homosexual intercourse, and three quarters did not know that HIV-infected people might not show obvious signs of illness (CDC, 2002). Compounding the lack of access to information is the social stigma surrounding the disease, echoing the government's response to the HIV epidemic. Condoms are also unavailable to most people, and, where available, social taboos make it difficult for unmarried people to get access to them, while fear of persecution discourages sex workers from carrying them.

Discrimination against people living with AIDS prevents people from seeking an HIV test and knowing their status. Laws and regulations have too frequently enforced discrimination and mandatory testing. UNAIDS reports a number of national and local policies that make testing mandatory for certain segments of the population, segregate AIDS patients for medical treatment, and ban those with AIDS from marrying, attending school, or pursuing work in a number of fields (UNAIDS, 2002). Such social and legal discrimination creates a difficult environment for implementing successful HIV prevention and care activities.

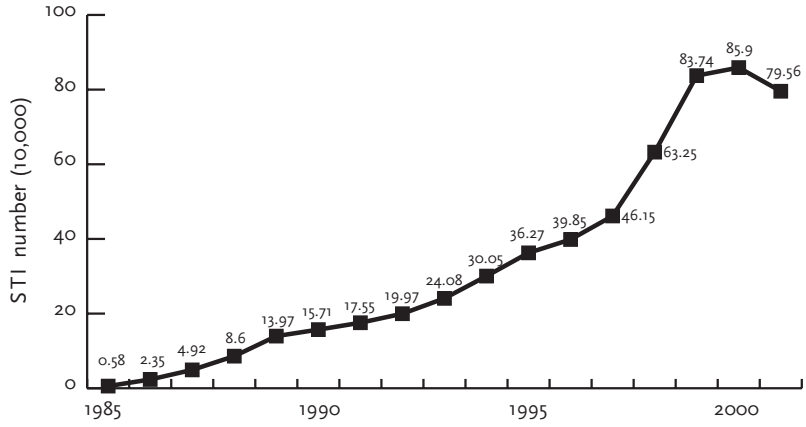
Lack of education, livelihood, and gender equality also make people, especially women, vulnerable to HIV. Both the quality of education and disparities across regions, ethnicities, and gender are troubling. Seventy percent of Chinese people who are illiterate are women, heightening women's vulnerability to HIV by denying them the knowledge and skills necessary to protect themselves against infection. Poverty promotes migration, commercial sex work, and commercial blood selling. It is associated with drug use, lack of education, and lack of awareness about HIV. Finally, gendered social norms dictate the behavior of men and women, resulting in men being more likely to engage in sex with more than one partner without using condoms, and in women being unable to control their sexual lives.

In addition, while traditional gender norms and taboos on the open discussion of sexuality already existed, the socioeconomic transition brought an increase in casual and premarital sex, including commercial sex work, creating the potential for a serious epidemic within the general population. Gill et al. report that, according to a 2001 survey, 27% of young respondents thought first sexual experience should occur within marriage, as opposed to 84% of respon-

dents in their parent's generation (UNAIDS, 2002). This dramatic change in sexual norms is reflected in the return of STDs following their near eradication in the 1950s. Since 1985, STDs have increased more than a hundred fold (Figure 2). Their proliferation, and the health care system's inability to treat them appropriately, will allow HIV to spread through heterosexual transmission even more easily. Abrams attributes this resurgence of STDs to:

> Privatization with its emphasis on personal aggrandizement; commodification of health care with resulting inequalities of access; the growing gap between rich and poor…the return of prostitution; the loosening of social controls which permeated China in the early revolutionary years; the influx of foreigners with foreign investment and tourism;…lack of adequate education about STDs;…the loss of the Cooperative Health Insurance System for the farmers; [and] the loss of the barefoot doctors and their replacement by a variety of private practitioners (Abrams, 2002).

FIGURE 2: TOTAL REPORTED STI CASES IN CHINA (1985–2001)



Source: The U.N. Theme Group on HIV/AIDS in China, "HIV/AIDS: China's Titanic Peril," June 2002.

Sandra Hyde provides a number of suggestions for STD prevention that draw on China's unique characteristics of normalized birth control, the new power of the market economy, and the potential integration of Chinese and Western medicine (see Hyde paper in this issue).

Under Mao, commercial sex work virtually disappeared. But with the opening of Chinese society, the sex trade returned and grew. Gill et al. cite increasing income gaps, women's poverty, labor mobility, consumerism, the commodification of women, and traditional gender norms as facilitating factors. New technologies like cell phones and pagers have moved the sex trade out of red light districts, making outreach and education more difficult (Gill et al., 2002).

Finally, a major structural factor creating countrywide vulnerability to HIV is the deteriorating health care system. The government was once the country's sole health care provider, but economic pressures have forced cuts in national and provincial health care budgets. Less than 10% of China's 900 million peasants have any form of health insurance. Health care costs have increased enormously, and local clinics are closing. By the mid-1990s, a mere 4% of the national health budget was spent in rural areas (Gill et al., 2002). The lack of health care services in China means that preventive education, STD treatment, and HIV counseling and testing are unavailable for the majority of Chinese. Joan Kaufman elaborates on the effects of privatization on the health care system in China, and the resulting obstacles for HIV prevention (see Kaufman paper in this issue).

Evidence of the effect of China's faltering health care system on the spread of HIV can be seen in the ongoing illegal blood trade. Indeed, to avoid the high cost of transfusions in hospitals, those needing transfusions are often advised to purchase blood directly from collection stations. China only has about .8 milliliters of blood per capita available for transfusions, as compared to the WHO recommendation of 7.0 milliliters (Gill et al., 2002).

An Effective Response

How has the Chinese government responded to the HIV epidemic thus far? In 1996, a National Coordinating Commission was established which issued the first action plan in 1998. However, 2001 brought a greater commitment to an effective response, with increased spending and the establishment of the Center for AIDS Prevention and Control within the Chinese CDC, a part of the Ministry of Health. That year also marked China's first international AIDS conference, greater media freedom to cover the disease, and the release of a new plan of action which called for increased government funding for prevention and care initiatives. In the plan, program objectives were set for 2002 and 2005 which emphasized eradicating illegal blood collection systems, increasing awareness, and improving the health care system's ability to deliver standardized HIV prevention and care services. UNAIDS criticized the action plan for continuing to conceptualize the HIV epidemic within a mainly medical framework, rather than placing it within the context of the larger structural causes highlighted above (UNAIDS, 2002). Other countries with high HIV prevalence rates have demonstrated the necessity of a comprehensive framework in controlling HIV's spread (UNAIDS, 2002).

Currently, only about 100 people receive combination antiretroviral (ARV) therapy in China (Kaiser Network, 2002). In October 2002, the Chinese government took steps toward making ARV treatment more widely available. It

announced its intention to eliminate duties and value-added taxes on imported ARV drugs and begin domestic production of four generic ARV drugs with the goal of making them more affordable (Kaiser Network, 2002). It also agreed to begin treating "thousands" of villagers in Henan affected by the unsafe blood collection system (Kaiser Network, 2002). In November 2002, GlaxoSmithKline submitted an application to the Chinese State Drug Administration to produce the ARV drug Combivir in China, the first commercial application of its kind; if approved, Combivir's price would be greatly reduced (Kaiser Network, 2002). Merck also recently announced that it would market a new version of the ARV drug Stocrin in China at a reduced price of $2.10 per pill (Kaiser Network, 2003). The greater availability of ARV treatment is welcome; it encourages voluntary testing, which allows programs to more readily identify HIV-positive individuals for prevention efforts. Furthermore, the provision of treatment changes the image of the disease from a death sentence to a condition one can live with healthily for many years.

The experience of other countries has demonstrated that the best chance to control the HIV/AIDS epidemic is to prevent its spread from high-risk groups to the general population. China is at such a point. To effectively curb its HIV epidemic, intensive prevention and care programs focused on IDUs and blood donors, including the provision of antiretroviral drugs, need to be implemented immediately. Almost 70% of reported HIV infections in China are in IDUs, and China's success in curbing the epidemic in this population will depend in large part on its willingness to implement large-scale harm reduction interventions, such as sterile needle and syringe access and methadone treatment programs (see Khoshnood paper in this issue). Such interventions would require a change in China's punitive approach to drug rehabilitation. Compulsory drug rehabilitation centers have a high failure rate; a change in focus within the re-education framework could start with provision of information about HIV and AIDS to drug users so they can better protect themselves.

Intensive efforts to lessen the vulnerability of the Chinese population, particularly CSWs, men who have sex with men, members of the floating population, and youth also need to be undertaken urgently. Countrywide awareness campaigns that include the promotion of condom use and school-based curricula that include sex education with information about HIV/AIDS and the promotion of life skills acquisition need to be implemented. China's intention to lift the current ban on condom advertisements is encouraging (Bezlova, 2002). In October 2002, China announced a promising plan to broaden public awareness of HIV/AIDS through 100 pilot projects that will provide comprehensive care (Kaiser Network, 2002).

China also needs to address the structural causes of the epidemic and strive toward achieving women's equality and greater access to sustainable livelihood. Increasing access to quality education, particularly for girls, is one of the most effective means of ensuring economic empowerment and gender equality later in life. A workable human rights framework that promotes non-discriminatory treatment of people with HIV and those at high-risk of infection is imperative. In October 2002, the city of Suzhou in Jiangsu province passed the first law to protect PLWAs (CDC, 2002); hopefully similar legislation will follow in other provinces and nationally.

Finally, improvements in the health care system that enable comprehensive HIV/AIDS care, including quality voluntary counseling and testing, effective treatment of STDs, and provision of ARVs, are vital for effective HIV prevention in China. There is much potential for China's family planning program infrastructure to provide HIV information and services to every household in rural China, as it has been able to do with its family planning messages (see Williams paper in this issue). Effective prevention of mother-to-child transmission (MTCT) programs should also be a priority, as HIV rates increase in women (Kaufman, 2002). Joan Kaufman addresses the constraints facing the health care system in setting up MTCT programs (Kaufman & Fang, 2002).

All these activities will require increased political commitment of high-level government officials at central and provincial levels in the development and implementation of appropriate policies, along with a corresponding increase in financial investment in prevention and care programs, and a willingness to acknowledge, at all levels of government, the existence of high risk behavior and the potential gravity of the epidemic. Eradicating the illegal trade in blood through enforcing high standards of blood collection is one of a number of pressing challenges requiring strong government leadership. Another is improving HIV/AIDS surveillance in order to better inform policy and resource allocation decisions.

The AIDS crisis should also be seen as an opportunity to strengthen civil society by allowing greater freedom of information and participation of affected individuals in decision-making. Non-governmental organizations (NGOs) working in AIDS prevention and care initiatives need to be legitimized and enabled to build capacity and partner with government agencies to accomplish program objectives. International experience has shown that, because HIV/AIDS afflicts marginalized and hard-to-reach populations, successful prevention and care must take place at the grassroots level where NGO involvement is crucial. Many successful models of prevention and care initiatives represent the work of NGOs. In the past, the Chinese government has not fully utilized and cooperated with

this indispensable sector of society. Indeed, China's initial grant proposal to the Global Fund for AIDS, Tuberculosis, and Malaria to support AIDS prevention, education, and treatment interventions was not funded because there was inadequate cooperation with civil society, including NGOs and PLWAs (Bezlova, 2002).

The financial and technical resources of the international community should be harnessed to guide China's response to the epidemic. The UNGASS Declaration of Commitment, endorsed in 2001, incorporates best practices that the international community has adopted and should be followed (UN Special Assembly). The World Bank has loaned $250 million to support HIV prevention programs in four Chinese provinces, and developed country governments (particularly the United Kingdom and Australia) have provided millions of dollars towards HIV/AIDS prevention in China. More of this type of support is needed.

The threat AIDS poses for the reversal of recent socioeconomic gains in China has spurred the government to take action. On World AIDS Day, December 1, 2002, the Chinese government launched a high profile anti-discrimination campaign, and announced that it would send one million students to rural areas in 2003 to bring awareness and anti-discrimination messages (CDC, 2002). It also began airing TV documentaries about HIV on over 1,000 local television stations (Bezlova, 2002). Let us hope that these actions are signs that the Chinese government is now committed to viewing AIDS as "a problem with a solution," as Kofi Annan urged (Kaiser Network, 2002). A comprehensive response that is based on human rights and international best practices, decreases structural as well as individual causes of vulnerability, addresses China's unique challenges in slowing the spread of HIV, and efficiently utilizes the resources at its disposal is urgently needed to prevent an even greater tragedy from afflicting China in the next decade.

Comprehensive Care for HIV/AIDS: China's Challenges and Opportunities

Ann B. Williams and Hong Wang

For more than a decade, a persistent stream of warnings regarding the potential for a major HIV/AIDS epidemic within the People's Republic of China went unheeded. As early as 1990, a privately sponsored conference on AIDS in China drew several hundred Chinese and American health care professionals to Beijing. Then, as now, the precise dimensions of the Chinese epidemic were obscured by secrecy, inadequate data, and an increasingly fragmented health care system. Nevertheless, although the extent of the epidemic remains unknown, it is now generally agreed that HIV infection is prevalent and that its incidence is rising rapidly in several distinct Chinese populations and geographic regions.

The Chinese government is not unique in its denial of the HIV/AIDS risk, nor in its reluctance to embark upon aggressive public health education to reduce that risk. It could, however, take advantage of lessons learned elsewhere in the world, should it choose to make use of them. Those lessons include not only the epidemiologic consequences of denial—as evidenced most recently and tragically in South Africa, where the prevalence of HIV rose rapidly in the face of government inaction to 20% of adults—but also lessons regarding the inextricable ties between prevention and care. The Declaration of Commitment issued by the United Nations General Assembly Special Session on HIV/AIDS (June 2001), responding to the unfortunate perception that poor countries must choose between HIV prevention for the uninfected and care for those already infected, emphasized the essential link between treatment and prevention and called for access to care for all HIV-infected people as part of an effective global response to the HIV/AIDS pandemic. Similarly, in a speech to HIV/AIDS researchers at a scientific meeting in Boston, President Bill Clinton highlighted

the importance of integrating programs of prevention, care, and treatment in order to stem the epidemic in resource-poor settings (Clinton, 2003).

Prevention is only one element in the continuum of a comprehensive HIV/AIDS public health strategy, a strategy that must include treatment and care. With the availability of treatment comes hope, which brings those at risk for HIV infection into contact with the health care system where they can receive important messages about secondary prevention and learn what steps to take to protect close contacts at risk. Effective antiretroviral treatment is ultimately cost effective because it returns HIV-infected individuals to productive lives and, by reducing viral burden, most likely contributes biologically to reduction in epidemic growth. Further, treatment dispels stigma because patients who feel and look better are able to return to work and care for families, and are no longer physically identifiable.

Another lesson from the past two decades is that implementation of an effective public health response to HIV/AIDS requires engaged political leadership along with commitment and compassion from health care professionals. In every country in the world where more or less effective programs emerged (Uganda, Thailand, Poland, Senegal, even the U.S.), physicians, nurses, and epidemiologists who understood the dimensions and consequences of the epidemic and the appropriate professional interventions, and who were willing to confront bureaucratic and political obstacles and lack of support from colleagues, led the way in concert with enlightened and determined civic policy makers.

The purpose of this paper is to review the elements of a best practices approach to clinical treatment and care of people with HIV/AIDS as established by UNAIDS and to consider the demands such an approach will place on Chinese society, professionals, and the health care system. Even if the Chinese epidemic is ten times current estimates, the scope of services required will not change, only the quantity. With luck, it is not too late for a best practices program of care to limit the expanding Chinese AIDS epidemic.

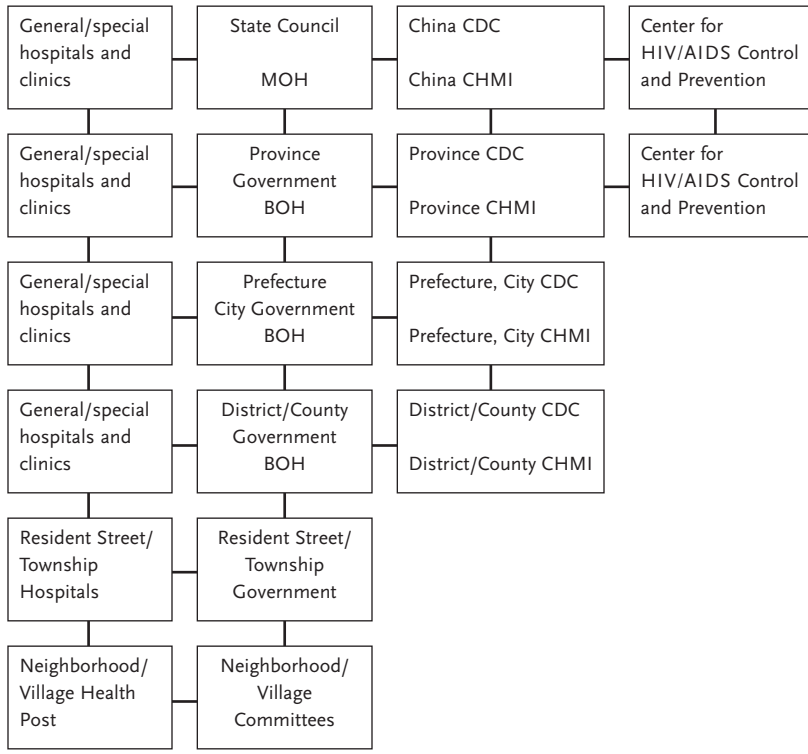
The Chinese Health Care System

With the Communist consolidation of power in 1949, China began to develop a national program to deliver comprehensive health care to its then largely rural population. The resulting system was widely acknowledged in the following decades as a model for low-income agrarian societies (Davis & Chapman, 2002). Although this comprehensive delivery system, which emphasized prevention and provided access to basic medical services for many Chinese citizens, dramatically improved the health of the population over the past half-century, it is currently facing enormous challenges generated by market-oriented economic reforms. In

this climate, the HIV/AIDS epidemic will stress every weakness in China's deteriorating primary and public health system. Five areas of vulnerability are described below.

First, because prevention and clinical care services are provided through two separate, parallel structures, coordination of prevention and care initiatives is very difficult (Figure 1). For example, tuberculosis control and prevention departments are located within the (Chinese) Centers for Disease Control, while tuberculosis care is provided through the infectious disease departments and hospitals. Following this model, the new Center for HIV/AIDS Control and Prevention has direct ties to the prevention structure, but limited opportunities to influence direct care services.

FIGURE 1: ORGANIZATION AND STRUCTURE OF THE CHINESE HEALTH CARE SYSTEM



In addition, family planning, a key element of an integrated HIV/AIDS program, is completely separate from the health care system. Family planning services are provided by Family Planning Stations at each level of Chinese civil

organization through the State Family Planning Commission, an organization that runs parallel to the health services delivery system. The Family Planning Commission, which is fully funded by the government, is widely viewed as a unique success story and there is great reluctance to integrate other health care services with family planning.

The second area of vulnerability is the lack of incentive for health care providers to deliver preventive services at the grass roots level. Privatization of health services means that many direct care providers, including rural clinics and the famous "barefoot doctors," no longer receive adequate financial support from local authorities, but must bill patients for services received (Strand & Chen, 2002). As in other fee-for-service health care systems, health education and prevention services are poorly reimbursed, if at all. Patients who struggle to pay medical expenses out of pocket, as most do, prefer to purchase curative services, procedures, and pharmacologic interventions over less immediately necessary prevention and health education services.

Third, there is no coordination among health institutions, even those that reside within a single hierarchical system, and the new economic incentives have led to competition among health care providers at different levels in the health care structure. Patients, unless they are covered by a structured insurance program, are no longer required to begin their quest for care at the local level, but are free to approach secondary or tertiary facilities directly, provided they have the funds to pay. In general, the technical level of medical care improves as the administrative level of the institution rises. Physicians working in the township and rural county hospitals (see Figure 1) are likely to have received only three to four years of training at a local health school, in contrast to those at the urban and provincial level hospitals, a larger proportion of whom will have a degree from a medical university and five to seven years of medical training (Strand & Chen, 2002). In addition, the equipment and physical conditions are better in the city and provincial facilities. Because these secondary and tertiary level hospitals provide general as well as specialized services, they offer an attractive option to patients seeking primary care who are prepared to pay for services.

Doctors working in the local clinics and hospitals are reluctant to refer even those patients they are not equipped to manage to a higher-level institution because they can not afford to lose the income these patients represent. Conversely, health care providers in the secondary or tertiary facilities may delay appropriately returning patients to the primary care level, in order to maintain their income stream, even though the patients could receive more convenient and inexpensive services at the lower level.

The fourth area of vulnerability is the increasing inaccessibility of health care services as a result of economic reforms and disintegration of the Township Health Centers. With the collapse of the rural health collectives, the majority of the rural population has neither access to primary health services nor funds to pay for them. The problem is not limited to the countryside: although there has long been a gap between rural and urban residents in terms of quality and availability of health care, that gap is narrowing in an unfortunate direction as an increasing number of urbanites lose their work-related access and struggle to pay for health care.

Fifth, and finally, although numerous laws and regulations purport to govern health care delivery and quality, there is no effective law enforcement entity to monitor compliance. The Center for Health Monitoring and Inspection was recently divorced from the prevention service delivery system, with the aim of improving regulatory enforcement. However, it is still too early to evaluate the effect of that change. The tragic HIV epidemic among rural people in Henan and other central provinces reflects the lack of enforcement of regulations governing blood collection practices.

The Continuum of Care for HIV/AIDS

Comprehensive care for people living with HIV/AIDS encompasses a number of services, in addition to standard medical interventions. While the Chinese health care system is vulnerable (as shown above), there are nevertheless opportunities to stem the tide of HIV and to improve the situation of those already infected and affected. In other countries, changes in the delivery of health prevention and care services initially targeted to the HIV/AIDS epidemic had the unintended consequence of improving the public's health in a broader context.

The essential elements of a continuum of care include 1) case finding through voluntary testing and counseling, 2) provision of antiretroviral medication, 3) prevention and treatment of opportunistic infections and other manifestations of HIV disease, 4) prevention and treatment of concomitant infectious diseases, among which tuberculosis is of particular concern, 5) prevention and treatment of sexually transmitted infections, 6) social and psychological support, 7) palliative care, and 8) prevention of secondary HIV transmission (UNAIDS, 2002). Full development of these services requires a political and social environment in which HIV/AIDS stigma is reduced, and in which men and women are able to act to care for and protect themselves and their families effectively.

Creating and maintaining a continuum of care is a multidisciplinary and community-based endeavor. In most parts of the world, the HIV/AIDS care team includes, in addition to nurses and physicians, an array of counselors, edu-

cators, and outreach workers, many of whom are volunteers. At the height of the epidemic in the U.S., nurses, family members, and volunteers bore much of the burden of caring for the growing number of dying patients. Traditions of social activism and volunteerism in the U.S. helped to initiate and sustain the development of model programs, but are not unique to that country.

For example, the essence of Philanjalo, a rural South African AIDS support program, is its cadre of village women who volunteer to visit neighbors with AIDS, not only providing emotional support but overseeing medication adherence. Their willingness to volunteer has brought hope and HIV/AIDS treatment to rural South Africans who are as impoverished and isolated as the villagers of China's Henan province. In Haiti, one of the poorest countries in the world, a successful rural program relies upon *accompagnateurs,* community members who monitor medication adherence and provide social and moral support to patients (Farmer et al., 2001). Without volunteers, public health and medical interventions around the globe would languish, failing to reach affected populations or to achieve effective implementation.

The unique profile of the Chinese HIV/AIDS care team has just begun to emerge. In China, doctors outnumber nurses 2:1 (Pang, Wong, & Ho, 2002), the tradition of public health nursing is not well established, families are shrinking and less able to take in sick relatives, social activism carries real risk, and volunteerism through non-governmental organizations is in its infancy. These factors will challenge the creation of comprehensive models of care. Nonetheless, there are traditions and elements of Chinese social organization that can support the work and that will lead to the development of distinctly Chinese community care programs.

Confucian values such as *xiao* (love within the family) and *ren* (benevolence toward others) are consistent with family and community-based models of care. Examples of nascent and developing activities that have recently raised social awareness of the need for care include a documentary film created by university students visiting Henan's AIDS-stricken villages, the work of Dr. Gao Yaojie in providing treatment to those villagers, and Dr. Wan Yanhai's unceasing public health education and prevention efforts through the Beijing Aizhixing Institute of Health Education.

Voluntary Testing and Counseling

Accurate diagnosis of individuals with HIV infection is essential. The majority of people living with HIV are unaware of their infection. UNAIDS names voluntary counseling and testing as the appropriate entry point into the HIV/AIDS continuum of care (UNAIDS, 2002). To effectively reach HIV-infected individ-

uals, counseling, testing, and follow-up services must be delivered without judgmental messages and in a safe social context in which individuals who are identified as HIV-positive are not stigmatized or otherwise punished as a result of their test results. In the absence of treatment and in the presence of likely retribution, there is no incentive for even those who know they are at risk to participate in testing programs. The current practice in some Chinese cities of requiring HIV-infected individuals to pay out of pocket for HIV tests and to report to the anti-epidemic station for test results seriously compromises the accessibility and effectiveness of the counseling and testing services in those communities.

In the early days of the HIV/AIDS epidemic in the U.S., when treatment was limited and discrimination and social repercussions prevalent, an extensive system of free anonymous test sites was developed. Individuals who thought they were at risk for HIV infection could visit one of these test sites where they were not required to provide proof of identity. After a counseling session, blood was drawn for HIV antibody testing. Clients were given a code name or number with which to return for their test results. At present, widespread availability of effective treatment and legal protection for HIV-infected patients has led to the dismantlement of this system, which was controversial from its inception.

However, some version of the anonymous approach may be worth considering to reach members of the "hidden" populations of Chinese at risk for HIV. When the activities that place one at risk for HIV infection are illegal or embarrassing, an opportunity for anonymous testing can provide useful information to both individuals and public health officials. For example, the young woman engaged in commercial sex work and her businessman client, the gay man in a heterosexual marriage of appearance, and the pregnant woman whose husband injects drugs might all respond to a testing campaign, if they knew they could remain anonymous. New, rapid test technologies are less expensive than in the past and mean that clients need make only one trip to the testing facility. Anonymous testing is a strategy best suited to environments where confidential voluntary counseling and testing are not an option or are not safe.

Ideally, HIV counseling and testing are integrated into primary care health services, including sexually transmitted infection clinics, drug treatment programs, family planning clinics, prenatal clinics, and primary care centers. Whether the testing is anonymous or confidential, the simple knowledge that one is HIV-infected will encourage some individuals to change their behavior, to protect at-risk close contacts, and when possible to choose a healthier lifestyle. However, for the real benefit of HIV counseling and testing to be realized, they must be linked to clinical treatment and social support. In this area, the lack of coordination between the prevention and care arms of the Chinese health care system,

and the separate status of the Family Planning Commission, pose a challenge. And, of course, the extremely limited availability of HIV-specific medications is a significant obstacle to effective and ethical testing and counseling programs.

Antiretroviral Treatment

Antiretroviral therapy and medical care for HIV-associated conditions is actually available everywhere in the world, if the patient can afford the cost. In that sense, China is no exception. A tiny subset of infected individuals has long received care in exclusive specialty hospitals in Beijing. The unanswered question is whether such care will be provided to the ordinary Chinese citizen with HIV and, if so, where and how that care will be delivered. The current system, in which HIV-infected patients receive treatment in specially designated centers, severely limits access to treatment in a country where patients are poor, resources limited, and distances long. The once-vaunted Chinese rural primary health care system has been substantially undermined by the last two decades of privatization. Nevertheless, however weakened, the system that includes village clinics and township health centers still exists and may offer the best mechanism to provide primary HIV/AIDS prevention and care to the rural population.

Management of antiretroviral therapy, once thought too complex and expensive for poor countries, is in fact easily within the capabilities of Chinese health care workers. The medication regimens are simpler and more tolerable than they were only one or two years ago. Simple clinical criteria can successfully identify patients with signs and symptoms of advanced HIV disease who will benefit the most from immediate therapy, even in the absence of expensive laboratory monitoring capability. The cost of effective drug combinations has dropped significantly in the face of worldwide protests, and China is beginning to produce generic versions of standard medications.

Price reductions notwithstanding, the cost of medications for HIV/AIDS remains a formidable obstacle for the majority of Chinese who need them. Given other demands for resources, it seems unlikely that the near future will see a Chinese version of the American Ryan White CARE Act, which provides federal funds for HIV/AIDS care for those who need it. However, opportunities exist for private industry and non-governmental initiatives, and these should be encouraged. A number of pharmaceutical companies have established foundations to support HIV/AIDS care, contributing their drugs at little or no cost to programs in poor countries. The African subsidiaries of some international corporations have begun to provide HIV/AIDS care to infected employees, judging it in the corporate best interest to protect the workforce. Similar corporations with operations in China should be encouraged to consider such programs. And,

the Global Fund to Fight AIDS, Tuberculosis and Malaria has made the financing of treatment access one of its core activities.

Adherence to antiretroviral medications, drug toxicity, and the development of medication-resistant viral strains are all appropriate concerns for any country launching a new HIV/AIDS treatment strategy. Unfortunately, most of what is known about these issues comes from experience in the wealthier countries and may not be directly applicable to the Chinese situation. For example, patients in the U.S. and Europe were heavily pretreated with sequential single and dual drug therapy before the advent of combination therapy and before recognition of the inverse relationship between adherence to the medication regimen and the development of antiretroviral resistance. The extent to which this scenario will be repeated in China is unknown. If the great majority of patients have no exposure to antiretroviral agents before the introduction of potent combination regimens, the Chinese may be able to achieve higher rates of viral suppression and ultimately reduce incidence of medication-resistant viral strains. But if less effective, minimal amounts and combinations of antiretroviral medications are widely distributed, a higher incidence of drug resistance can be expected.

Medication adherence, or the extent to which a patient follows his or her prescribed drug regimen, is key to treatment effectiveness, but is poorly understood. Individual adherence behavior is surely socially and culturally influenced. While the vast majority of adherence or compliance (to use the older term) research was conducted among North American and European populations, little is known about how the results of that research apply in the rest of the world. Medication non-adherence is widely described among North American populations. In contrast, in an otherwise empty, dirt-floored hut in South Africa, an emaciated man carefully stores his medications in a cardboard box by his head where he sleeps. Finding food is this man's major problem; he gratefully takes the medications that have saved his life and is unlikely to forget to do so.

Will the behavior of Chinese villagers more closely resemble North American research subjects or that of the South African man? Chinese nurses, physicians, and behavioral scientists will have to learn more about the meaning of medication and the factors that influence medication adherence for their patients. Concerns about adherence are reasonable, but should not be used to delay introduction of antiretroviral therapy in China.

Chinese Traditional Medicine

Chinese traditional medicine is an important element of Chinese health care and must be included in any HIV/AIDS treatment strategy. Collaboration with Chinese traditional medicine practitioners offers an opportunity to reach people

at risk who might seek Western-style care late in the course of disease, if at all. Many of the symptoms of HIV infection are non-specific and generalized, such as fatigue, weight loss, nausea, and vomiting; and may respond to traditional Chinese medicine. Similarly, traditional medicine may be of use in amelioration of treatment-induced side effects, such as nausea or peripheral neuropathy.

There are traditional Chinese medicine hospitals at the county, city, provincial, and central levels. In those institutions, Western medical techniques supplement traditional Chinese medicine services. Conversely, in Western-style medical hospitals, there is usually a traditional Chinese medicine department to supplement the Western medical services. It is important that Western and traditional medicine practitioners work collaboratively given the significant potential for drug interactions between traditional and modern agents. While very little is known about the effect of traditional medicinal compounds on antiretroviral drug levels, it is reasonable to assume at least some compounds will interact.

In the U.S., Africa, and Europe, claims by traditional or alternative healers to have discovered (and put a lock on) a cure for AIDS have undermined treatment outreach efforts and tragically kept some people from seeking or accepting effective care. Such claims are not unknown in China where prophylactic "sex" sprays and creams are widely marketed and said to protect the user from a large array of sexually transmitted infections, including HIV. Further, despite being illegal, shamanistic healing is widely practiced in the Chinese countryside. In one survey, 74% of rural patients seeking outpatient psychiatric care had previously consulted local witch doctors (Li & Phillips, 1990). While little is known about the contemporary prevalence of these practices, it is reasonable to assume that they still exist and that the meaning assigned to HIV/AIDS by rural shamans will influence at least some patients' beliefs regarding effective prevention and cure.

Implications of HIV/AIDS for Concomitant Health Problems

Tuberculosis

In most parts of the world where HIV is a significant presence, tuberculosis rates are also high. One third of the world's population is infected with *M. tuberculosis*. When an individual's immune system is weakened by advancing HIV infection, active tuberculosis disease is often one of the first clinical manifestations. Where the two epidemics intersect, many HIV/AIDS-related deaths are the result of activation of latent tuberculosis infection. Moreover, tuberculosis is more often fatal in the setting of HIV infection. Worldwide, tuberculosis is the leading cause of death among people with HIV infection (UNAIDS, 2002).

Tuberculosis is the most prevalent infectious disease in China. One third of the population, 400 million people, is infected and there are 5 million active cases, 80% in rural areas. Nearly 150,000 people die from tuberculosis annually (World Health Organization, 2000). From 1992–1999, China used World Bank loans to support a tuberculosis control program in 13 provinces, while the Ministry of Health conducted similar programs in 15 additional provinces. Reportedly, 1.2 million people received free diagnosis and treatment, and cure rates increased from 50% to 90% in those regions where programs were active (China State Planning Council, 2001). However, tuberculosis is far from under control in China at present. Factors limiting success include the lack of public awareness and health education, lack of accurate diagnosis, inaccessibility of effective treatment, failure of patients to comply with long-term treatment regimens, growing population mobility, and increasing incidence of drug-resistant tuberculosis.

It is predictable that the number of active cases of tuberculosis will increase parallel with rising HIV rates. Because active tuberculosis is highly infectious, treatment is essential for the health of the community. Treatment of tuberculosis is equally effective for HIV-infected people as for individuals who are not HIV-infected. In those places where an effective tuberculosis surveillance and treatment program is in place, the integration of tuberculosis and HIV services offers a powerful strategy for control of both epidemics.

Directly observed therapy (DOT) is the cornerstone of most effective tuberculosis control programs; and DOT is offered in China, often with financial support from the international community. Xinjiang province, with some of the highest tuberculosis rates in China (and a growing HIV epidemic), was an early site for DOT. Where these programs are in place, tuberculosis treatment is available at no charge. The development of effective, once-a-day, antiretroviral regimens for HIV infection opens the door to new, combined programs of DOT for both tuberculosis and HIV. Such a strategy is currently being pursued in South Africa, with encouraging initial success (Jack et al., 2003).

Hepatitis

Hepatitis B and C viruses (HBV, HCV) are prevalent in China; as many as 60% of the population may have been exposed to hepatitis B alone (Zhao, Xu, & Lu, 2000). A substantial number of those with HBV can be expected to develop liver cancer, which is the leading cause of cancer-related death in China. The high prevalence of HBV in China likely stems from unsafe needle practices, not only among users of illicit drugs, but in the general population and within the health care system itself. Frequent use of injections to treat common health problems,

reuse of inadequately cleaned injection equipment, and poor understanding of the principles of universal precautions among health care workers certainly contribute to this problem (UN Theme Group on HIV/AIDS in China, 2002). These practices are of concern because they allow transmission of other blood-borne infections, including HIV. HBV does not appear to significantly influence the progression of HIV infection, nor does HIV infection accelerate progression of HBV liver disease.

However, the same is not true for HCV infections. Although the dimensions and implications of HCV infection in China are even less well known than those of HIV, HCV coinfection prevalence in one cohort of illicit drug users in Yunnan approached 100% (Zhang, Yang, Xia, et al., 2002). Experience in Europe and the U.S. suggests that HCV-related morbidity could be substantial in the coming years. HIV coinfection has been associated with a more rapid progression of HCV-induced liver disease as well as a higher prevalence of cirrhosis. In addition, coinfection with HCV may lead to a higher rate of antiretroviral-associated hepatotoxicity.

Because some antiretroviral agents are associated with hepatitis, it will be important that the choice of treatment regimens used in China take into account the prevalence of hepatitis viruses, particularly if regimens are dispensed with a minimum of laboratory monitoring.

Sexually Transmitted Infections

Sexually transmitted infections (STIs), well controlled in the 1950s and 1960s, are again on the rise in China (Chen, Gong, Liang, & Zhang, 1999). Early identification and treatment of these infections are key to halting their spread. Unfortunately, stigma associated with these conditions leads to delay in seeking care, inaccurate diagnoses, inadequate treatment and failure to inform partners; all these factors are contributing to the new epidemic (UN Theme Group on HIV/AIDS in China, 2002).

Many people who suspect they have acquired an STI seek care outside the government-controlled health care system, leading to delay in receipt of effective treatment (Choi, Zheng, Zhou, Chen, & Mandel, 1999). Private clinics, unlicensed doctors, drug stores, street advertisements, and hotel brochures all offer to provide confidential cures for these embarrassing social problems. Data are limited regarding the quality of services provided through these channels, but what is available suggests that diagnoses are not properly made nor treatments appropriately recommended (UN Theme Group on HIV/AIDS in China, 2002). The potential contribution of inappropriate antibiotic use to the development of antibiotic-resistant organisms is worrisome. Efforts to enforce regulations aimed

at improving the quality of care provided in the alternative STI treatment structure have been sporadic and ineffective.

Individuals with one STI are at risk for contracting others concomitantly, including HIV. Unfortunately, the pattern of care-seeking behavior described above deprives a population that is at significant risk from easy access to government-sponsored education and prevention programs. Integrating HIV prevention and care into a more effective STI treatment system will be an important challenge in China. "Hidden" populations at risk for both STIs and HIV, such as male and female sex workers, men who have sex with men, men who patronize commercial sex workers, and illicit drug users, are unlikely to present at official health facilities with STI-related complaints. Innovative outreach approaches will be required.

Mental Health Problems: Suicide

Although Chinese health statistics are notoriously unreliable, suicide is clearly a leading cause of death. China is home to 27% of the world's population, but accounts for 44% of the global burden of reported suicides and 56% of female suicides (Murray & Lopez, 1996). Further, the Chinese pattern of suicide uniquely includes higher rates of suicide in rural than urban areas. Rates of completed suicides are particularly high among rural women (Phillips, Li, & Zhang, 2002). It has been suggested that in rural villages the combination of acute stressors, limited social support, and easy access to lethal pesticides leads to suicidal death as a result of impulsive behaviors that are not always intended to be fatal. In most instances, the acute stressors reported to have precipitated the behavior are related to family conflicts (Pearson, Phillips, He, & Hutyu, 2002).

Little is known about the precise relationship between AIDS and suicide elsewhere in the world, but some early studies suggest that the risk is considerable (Marzuk et al., 1988; Rundell, Kyle, Brown, & Thomason, 1992). Depressive symptoms are common among people with AIDS (Lyketsos et al., 1996). Anecdotal information from Beijing nurses caring for AIDS patients and from the local "hot lines" suggests that depression and suicide are also important AIDS-related mental health concerns in China. Further, the already high risk for and impulsive nature of suicidal behavior among rural Chinese women must be seriously considered when programs for widespread screening of pregnant women are developed. These women will need not only assurances of confidentiality but social support and protection when the test results are positive.

Role of Health Care Workers

Providing clinical care for patients with HIV/AIDS requires knowledge, compassion, and commitment. It also requires courage, because there is some personal risk. In the U.S., the risk of infection after a documented percutaneous exposure to HIV-infected blood is approximately .3%. This risk, which is small but real, probably can be reduced with the prophylactic use of post-exposure antiretroviral medication. While there are no data describing risks for occupational exposure to HIV in Chinese health care facilities, the high rates of hepatitis B seroconversion among nurses and medical students and self-reported frequency of injuries with needles or medical sharps (Phipps et al., 2002) suggest that risk for HIV exposure is substantial and will increase as more and more HIV-infected patients are seen.

To ensure that patients with HIV/AIDS receive adequate care, Chinese physicians and nurses first must understand how to protect themselves. Earlier experience elsewhere in the world taught that inadequate information and fear of occupational exposure compromise the ability of doctors and nurses to provide compassionate and competent care to patients with AIDS. Implementation of universal precautions is essential and rare in Chinese health care facilities.

Clinical educational programs for health care workers require not only didactic information, but also interactive components that provoke the participants to explore the social and personal facets of the work. Data from work with nursing students in Hunan confirm the hypothesis that provision of knowledge is not enough to change attitudes and that willingness to care for HIV-infected patients is associated with the opportunity to participate in interactive learning activities that address the affective learning domain (Burgess, Watkins, & Williams, 2001; Wang, Fennie, He, Burgess, & Williams, 2003).

In addition to HIV-related epidemiology, pathophysiology, physical diagnosis, and pharmacological treatment, Chinese nurses and physicians will need to expand their concept of disease management. For example, most Chinese health care workers have limited psychosocial training, but will need these skills to care for patients with HIV/AIDS. Of particular importance are training in addictive diseases, suicide prevention, and support services for those clinicians who bear the greatest burden of caring for patients.

Professional HIV/AIDS education in China must include practitioners of Chinese traditional medicine. Collaboration with this group offers the opportunity to provide prevention education, early diagnosis, and clinical referrals to dispel myths about the etiology and natural history of HIV/AIDS to patients who might otherwise not come to Western-style clinics or hospitals. Providers of traditional medicine therapeutics need to be aware of when to refer patients for

HIV testing and need to understand and adhere to principles of universal precautions as they provide care.

Conclusion

The road ahead is long. There is no doubt that a substantial HIV/AIDS epidemic is already under way, but the opportunity remains to respond effectively and with compassion. The recent epidemic of Severe Acute Respiratory Syndrome (SARS) highlights China's public health strengths and weaknesses. Lack of reliable reporting systems and local officials' fear of retribution for reporting bad news continue to obstruct implementation of effective SARS containment measures. On the other hand, once the government decided to go public with its SARS problem, the vast official propaganda network swung into action, and the entire population was mobilized in the "fight" against SARS. A similar effort to prevent HIV infection and provide care for those already infected is needed, driven by the evidence-based best practices guidelines of the international AIDS community.

Social Vulnerability of Injection Drug Users to HIV/AIDS in China: Determinants and Responses

Kaveh Khoshnood and Stephanie Weber

This paper will discuss three key topics regarding the epidemic of HIV/AIDS among drug users in China. First, it will describe the emergence of the HIV/AIDS epidemic among drug users in the context of the overall emergence of HIV/AIDS. Second, it will examine the specific ways in which drug users are socially vulnerable to HIV/AIDS in China. Specifically, it will analyze the demographic, epidemiologic, legal, and social factors that contribute to the social vulnerability of Chinese drug users to HIV/AIDS. Third, it will discuss the prospects for an effective response to reduce transmission of HIV/AIDS among drug users in China.

The authors, an epidemiologist and a policy analyst, who share a strong belief in the principles and efficacy of harm reduction in prevention of HIV/AIDS among drug users. The main source of information used in this analysis is printed materials published in the English language. These include academic articles from peer-reviewed journals, reports from various Chinese government departments and international agencies, and reports produced by international NGOs. In addition, the analysis is informed by the authors' extensive field experience with drug users in the U.S., modest field experience working with drug users and other at-risk populations in China, Russia, Tajikistan and Iran, and extensive discussions with Chinese and international experts in the field of harm reduction.

Why Harm Reduction?

The second decade of the HIV/AIDS epidemic witnessed a growing dissatisfaction with the preoccupation with individual risk reduction and an increasing awareness of the importance of examining and responding to the societal factors that influence such behavior. The old concepts of "risk behaviors" and "risk groups" were slowly replaced with the concepts of "vulnerabilities" and "vulnerable groups." While a thorough examination of this change in phenomenology and its roots and consequences is beyond the scope of this paper, suffice to say that this paradigm shift resulted in development of much broader strategies for prevention of HIV among drug users worldwide. This new paradigm came to be known as "harm reduction," defined by its proponents as, "policies and programs which attempt primarily to reduce the adverse health, social, and economic consequences of mood-altering substances to individual drug users, their families and their communities" (Wodak, 2002).

Emergence of HIV/AIDS among Drug Users in China

The epidemic of HIV/AIDS among drug users in China was first identified in 1989 among injection drug users (IDUs) in Yunnan, a province located in the Golden Triangle region bordering Myanmar, Laos and Vietnam. Since that time, IDUs have continued to represent the majority of reported HIV infections in China (approximately 70%) (UNTG, 2002). Of this 70%, two-thirds live in rural areas and 90% are between the ages of 20–50 (China Ministry of Health, 2001). Molecular epidemiology has linked the spread of HIV sub-types to specific drug traffickking routes in China (Beyrer, Razak, Lisam, Chen, Lui, & Yu, 2000).

Since infection in Yunnan, serious epidemics among IDUs in China have been documented in Xinjiang, Guangxi, Sichuan, Guangdong, Gansu, and Jiangxi, among others (UNDCP, 2000; UNAIDS, 2001). Yunnan, Xinjiang, Guangxi, Guangdong, Sichuan, and Jiangxi have been the hardest hit provinces, with infections rates of up to 80% (UNTG, 2002).

It is generally accepted that the HIV/AIDS epidemic in China has evolved in three distinct phases. Phase one lasted from 1985 to 1988, and all cases were limited to foreigners or overseas Chinese. The cases tended to be confined to the seven provinces along the coast. Phase two began in 1989 with the spread of HIV among IDUs in Yunnan province (as noted above). By 1993, the epidemic in China had spread to 21 provinces and was chiefly confined to IDUs. Ethnic and minority groups were significantly over-represented among those infected. Phase three commenced in 1994 and was marked by an increasing proportion of infections attributable to blood/blood products-related and sexual transmission (UNAIDS, 2000).

Currently, the epidemic has spread to all 31 provincial-level units of China, is well entrenched among the majority Han group, and is increasing among women drug users (UNAIDS, 2000). The vast majority of those infected are between the ages of 15–49. In 2001, the ratio of male to female infections was approximately 5:1; and the most frequent mode of transmission of reported HIV infections was sharing of contaminated injecting equipment among IDUs (UNTG, 2002).

Social Vulnerability of Drug Users to HIV/AIDS in China

What are the factors that put drug users in China at risk of HIV? As phrased, this question can be problematic because it suggests that drug users in China are a homogenous and distinct group of individuals that can be readily categorized and studied. In fact, similar to drug users in other countries, Chinese drug users are an extremely heterogeneous group in their socio-demographics, type, and method of use. This paper focuses primarily on drug users whose current mode of drug use is injection. As with other "hidden" populations, information about the size and characteristics of drug users in China is incomplete.

Despite the limitation of the existing data, one can easily conclude from the published reports that drug use in China is common and increasing. The number of registered drug users has increased rapidly from 70,000 in 1990 to 900,000 in 2001 (UNTG, 2002). Unofficial sources put the current figure of drug users much higher at approximately six to seven million drug users, with nearly half being injectors (Reid & Costigan, 2002). Of China's 2,143 counties, 2,033 have reported drug problems (Sharma & Burrows, 2002). Of these, 140 counties report more than 1,000 registered drug users (Wu, cited in Reid & Costigan, 2002). Beijing, which was previously thought to be relatively drug free, is now estimated to have between 50–60,000 drug users (NCAIDS, 2001). Unofficial sources put the current figure of drug users much higher at approximately six to seven million drug users, with nearly half being injectors (Reid & Costigan, 2002).

Most drug users are male and under the age of 30; however, the proportion of female drug users has increased in the last decade in selected provinces (Wu, 2001). Factors contributing to this increase have not been adequately examined. In a review of existing research by Wu (2001), it was found that the average age of female drug users is considerably lower than male drug users (between 22 and 27). Moreover, about half of the female drug users had engaged in sex work, and syphilis rates among them varied between 1.4–29.2% (Wu, 2001).

Drug of Choice

Heroin and opium are the main drugs of choice among drug users in China, though the popularity of opium appears to be declining (Reid & Costigan, 2002). Increasing amounts of Amphetamine Type Substances (ATS) are being seized, indicating that methamphetamines (widely known as "ice") are also becoming an increasingly popular option (Sharma & Burrows, 2002; Reid & Costigan, 2002). This increase in popularity is a result of widespread availability and lower price of ATS as compared to heroin. Cannabis use appears to be localized rather than widespread, even though there has been a significant increase in cannabis seizures in recent years (up from 106 kg in 1999 to 4,493 kg in 2000). Pharmaceutical drugs such as diazepam, triazolam, pethidine, and buprenorphine are also used, often in conjunction with other drugs. The use of morphine, cocaine, ecstasy, illegally acquired methadone, dihydroetorphine, and tramadol has also been documented (NNCC, 2001; UNDCP, 2001; NCAIDS, 2001, cited in Reid & Costigan, 2002).

Mode of Drug Use

A trend in mode of use among heroin users in Asia in the last two decades has been a transition from oral, smoking or chasing methods to injecting (UNTG, 2002; Reid & Costigan, 2002; Razak, 2002). Reports range from 50% to 80% of heroin users preferring injection (Razak, 2002). The second National Epidemiological Survey conducted by Wei Hao et al. (2002) found the proportion of drug users who inject had increased from 25.5% in 1993 to 31% in 1996. One explanation for this trend is a view that injecting is a more cost-effective mode of use.

Among those who inject, risk practices such as sharing of injecting equipment appear to be common, and the continuing high prevalence levels of HIV among IDUs bears testimony to this. Studies indicate that the proportion of those who share equipment is often as high as 60%, despite availability and affordability of needles and syringes from pharmacies (Razak, 2002; Sharma & Burrows, 2002; UNTG, 2002). However, most reports discussing availability of syringes are from urban settings. Lack of anonymity and threat of disclosure through local pharmacists in rural settings might present a barrier to accessing sterile syringes for rural drug users. Specific practices such as using blood as a solvent or unsafe cleaning methods have also been documented (Reid & Costigan, 2002).

Reports have found that accessing sterile needles and syringes in urban areas in China is not difficult because they are sold legally at pharmacies and medical clinics with prices ranging from .5 to 1 yuan. However, relative availability of

clean syringes and needles in urban areas hides existing barriers to IDUs. These barriers include: harassment by the police, inconvenient hours of pharmacies, and a disparaging attitude of pharmacists towards IDUs. Of these barriers, harassment by the police creates the largest challenge for IDUs to accessing clean needles. Examples of police harassment include arresting drug users for carrying needles (both new and used needles) and following drug users out of pharmacies in order to arrest them. These actions derail the ability of internationally-accepted harm reduction best practices to stop the spread of disease.

Availability of Drug Treatment

Chinese drug regulations have significantly impeded health professionals' efforts in China to implement internationally-proven harm reduction best practices, especially needle exchange and methadone maintenance programs (Yap, Wu, Liu, Ming, & Liang, 2002). Harm reduction strategies among IDUs in China have not been implemented nationally because provision of needles and syringes and methadone maintenance to drug users has been interpreted by Chinese law as "assisting drug users and promoting prohibited drugs and drug use" (Yap et al., 2002). Given these barriers, harm reduction programs among drug users are only available through a few pilot projects reaching a small fraction of those who need these services.

As of August of 2002, needle social marketing had been pilot tested in Guangxi and was in the process of being expanded to six counties in Guangxi and Guangdong provinces (Wu Zunyou, personal communication). Nonetheless, the need exists to expand the program nationally, particularly in those areas hardest hit by the HIV epidemic among drug users.

Criminal Penalties

The government's stance with regard to drug users is to identify them and send them to compulsory drug rehabilitation centers (UNTG, 2002). Rehabilitation centers focus on detoxification and moral/legal education. Outpatient programs are few, follow-up minimal, and the relapse rate is estimated to be over 90% within 5 years (UNTG, 2002).

With the greater decentralization of public health and public security, departments have been forced to generate their own income. One result of this move has been the rise of economic incentives to arrest users and maintain a quota of users in detoxification centers. Additionally, investigators have reported the existence of mandatory "exit fees" from detoxification centers (Yap et al., 2002).

Social Status and Stigma

> A drug user in China is in an extremely vulnerable situation because he or she faces both the toll of poverty, that of discrimination, and lack of information.
>
> UNTG, 2002

There has been a growing recognition of the negative role of stigma in the overall health of stigmatized groups. Stigmatized groups often delay seeking health care, receive poor health services, and suffer from low self-esteem and self-worth, all of which lead them to self-destructive behavior and make them vulnerable to sexual exploitation and other forms of abuse. There is evidence that drug users in China are among the most stigmatized groups, particularly those who are members of ethnic minority groups. Many drug users in China are illiterate, lack formal education, and are out of school and/or unemployed (UNTG, 2002). Moreover, in Chinese society there is often a lack of understanding of the mechanism behind drug use; as a result, there is little sympathy or support for drug users.

Prospects for an Effective Response

Need for Massive Scaling-up of Pilot Projects

The current response to the epidemic of drug users in China can be characterized as inadequate, fragmented and contradictory. While progressive public health programs based on international best practice models of harm reduction have been pilot tested in various provinces, these efforts remain extremely small and uncoordinated. Massive scaling-up of successful pilot projects (such as needle exchange programs, methadone treatment programs, and 100% condom campaigns in sex establishments) needs to proceed rapidly and be monitored closely for efficacy. This will only be possible with a massive increase in financial and logistical support from the central government.

Need for Paradigm Shift Towards Harm Reduction and Away from Criminal Justice Approaches

Noticeably absent from much of the existing harm reduction program for prevention of HIV among IDUs is the Public Security Bureau (PSB). International experience has repeated the absolute need to harmonize public health approaches with criminal justice approaches in dealing with twin and entangled epidemics of HIV/AIDS and addiction. There is a clear need for innovative projects to train and engage China's enormous public security apparatus in harm education efforts now being implemented by the health sector.

Shift of Resources from Supply Reduction to Demand Reduction

China, like many other countries in the region and in the West, including the U.S., spends far more of its resources on supply reduction efforts (interdiction, border patrol, arrests, incarcerations, etc.) at the expense of developing drug prevention campaigns and drug treatment programs. This imbalance in approach must be corrected to stem the rising tide of new drug users and reduce the adverse health consequences among those already addicted. The most urgent need for prevention of HIV and other blood-borne infections among drug users in China is for massive development of methadone treatment programs that have proven to be the most effective form of treatment for heroin addiction and strongly associated with a reduction of HIV incidence among its participants (Metzger, Navaline, & Woody, 1998).

Expanded Access to Sterile Syringes

The most immediate harm reduction strategy to reduce the transmission of HIV among IDUs is the expansion of access to sterile syringes throughout China. This is particularly important in rural areas where access to sterile syringes is more restricted. Strategies to achieve this goal include large scale and numerous Syringe Exchange Programs (SEPs), and distributions of free or low cost syringes through pharmacies or other venues such as vending machines. However, increasing availability of syringes is only effective if it is coupled with policy and procedure changes of the Public Security Bureau. If police forces continue to harass drug users who carry syringes for evidence of their drug use, increasing the availability of syringes will not necessarily result in the desired outcome of a reduction in sharing of syringes, since many drug users will be reluctant to carry syringes with them.

Reducing Stigma Attached to Drug Use and Minority Status

Anti-stigmatization legislation and programs must be implemented and supported by high-level leadership of the country to create a safe and non-discriminatory environment for these populations. This would be a crucial prerequisite for the participation of drug users and other stigmatized groups in HIV/AIDS prevention programs.

Conclusion

There is evidence that HIV epidemics among IDUs in both developed and developing countries can be prevented, slowed, and even reversed through the above-mentioned strategies. However, no single element has been found to be effective on its own. The complexities of controlling the spread of HIV/AIDS

among IDUs require commitment and action across many different sectors. Evidence from other countries strongly suggests that national HIV/AIDS, drug control, and health policies that have mechanisms for coordination among ministries, NGOs, and the private sector are critical features of an effective response (Ball & Crofts, 2002). Additionally, the government of China must be encouraged to promote harm reduction over criminal justice and to enact specific measures that reduce stigma and discrimination. Currently, there is an urgent need for these actions to take place.

Research Note: The Importance of Research on Male Sexuality in China for Effective HIV/AIDS Prevention Programs

Elanah Uretsky★

An epidemiologic paradigm framed by "high-risk" behaviors of female commercial sex workers, injection drug users and men who have sex with men has helped shape the construction of the global HIV/AIDS pandemic. These same behavioral categories inform many prevention and intervention programs that are designed in response to the pandemic. Such programs, however, can only achieve limited effectiveness because they neglect the needs of vulnerable people who neither fit nor identify with the behavioral categories highlighted by the epidemiological model. The male clients of female sex workers comprise a large part of the population that is both vulnerable to HIV infection and neglected by most HIV prevention and intervention programs. The success of HIV prevention and intervention programs worldwide depends in part on their ability to include *all* men in their target populations, regardless of the sexual or gendered identity of their sexual partners. This will require further research on male sexuality and masculinity that asks questions of how men choose their sexual partners, where they pursue sexual relationships, and why they pursue certain types of sexual relationships. Pioneering social science literature on the relationship of male sexuality and HIV/AIDS highlights the importance of designing messages that are influenced by local constructions of masculinity and male sexuality, but they often focus on men who have sex with men (see Dowsett, 1996; Parker, 1999; Carillo, 2002). Similar research will also be crucial for informing future HIV prevention messages in China but it is particularly important to extend this discussion to include all men as China witnesses trends where extramarital affairs are increasing, millions of women (and men) are pursuing economic prosperity through commercial sex work, and many gay men still feel social pressure to

marry, have a child, and live a heterosexual lifestyle in public for fear of political retribution.

Several factors limit the effectiveness of HIV prevention programs designed specifically to target "high-risk" populations. To begin with, an emphasis on female commercial sex workers as a "high-risk" population reinforces the stigma attached to this label. The epidemiologic framework that highlights female commercial sex workers as a high-risk population has caused these women to be identified as "reservoirs of HIV infection" and "amplifiers of the HIV epidemic" (de Zalduondo, 2000). This actually hampers our ability to respond effectively to the pandemic by limiting avenues for prevention and by building hostility against populations that are already socially stigmatized. The epidemiologic framework of HIV/AIDS is typically associated with sexual behavior that is considered "inappropriate" to local gender norms. Within the exchange of sex, stigma is naturally assigned to sex workers since the provision of sex and not necessarily its consumption is associated with expressions of non-normative social behavior. (Parker & Aggleton, 2002).

In China, prostitution was historically assigned to women who were socially classified as debased (*jian*), a social class that was expected to serve as society's prostitutes, thieves and renegades. Men who solicited prostitution services were not socially castigated as long as they pursued sexual services from a woman classified as *jian*. Such service was socially proscribed, however, from women classified as good (*liang*) (Sommer, 2000). Sex work is illegal in contemporary China, and women accused of prostitution are subject to heavy fines and incarceration. But the demand for female commercial sex workers is fueled by men who are often socially expected to solicit the services of these women. The social stigma already assigned to sex work has facilitated classification of female commercial sex workers as "vectors of infection." The stigma and discrimination assigned to female commercial sex workers because of their social status and association with HIV transmission limits the reach of programs that isolate them as a "high-risk" group because many women fear the repercussions of being identified as a sex worker. Women in China are particularly sensitive to suspicions of their involvement in commercial sex work because of the harsh fines and penalties.

Standard HIV prevention messages that target "high-risk" populations are further limited in their effectiveness because the epidemiological model does not account for the potential impact that male clients of sex workers have on HIV transmission. Effective prevention programs should help men realize the role they play in transmitting HIV by asking them to look reflexively on their own societal positions (Whitehead, 2001; Grieg, Kimmel, & Lang, 2000). It is important, however, to realize that HIV prevention messages in China, as elsewhere, should

not privilege a hegemonic notion of men and male sexuality. Instead, various designs are needed to target men in myriad social and economic situations who pursue sex for different purposes and seek out sexual relationships from women and men who occupy varying positions in a complex sexual hierarchy. Pan Suiming has identified seven levels of female commercial sex workers that range from second wives (*er nai*) who cater to the sexual needs of wealthy Chinese men, to the "women who live in a tent" (*zhu gongpeng*), who provide sexual services to poor migrant men. The famous *santing* or *sanpei xiaojie* (bar hostess or literally "three accompaniment miss" so called for her accompaniment in singing establishments, dancing establishments, and eating establishments) and the common streetwalker are also included in his matrix (Pan, 1999). The men who occupy this sexual hierarchy pursue and use sex for different reasons, and live in widely varying social contexts that require the design of HIV prevention messages that target a broad range of social and economic situations. Economic reforms are inducing diverse social conditions that engender a variety of new and reemerging attitudes toward sexuality as well as sexual desires among urban, rural and migrant men that do not necessarily intersect. The varied social, economic and political conditions that distinguish these attitudes and desires also influence the multiple spaces occupied by these men within China's sexual hierarchy.

Even migrant men cannot be approached as a monolithic population in the design of HIV prevention messages targeted at Chinese men. Within the migrant population we can distinguish at least three groups of men including long distance truck drivers, the floating population (*liudong renkou*) and construction workers (*jianzhu gongren*). Concern over the vulnerability of long distance truck drivers to HIV infection has been noted in several countries affected by HIV/AIDS. Truck drivers often provide transportation to women in exchange for sex, or solicit sex from women at truck stops in exchange for lodging (Parker, Easton, & Klein, 2000). Temporary migrants who move back and forth between their natal rural villages and either large urban or other rural areas must also be viewed as two more distinct populations that are vulnerable to HIV infection because of distinctive social situations. The term "floating population" (*liudong renkou*) that is most commonly used to discuss China's migrant population refers to people who migrate temporarily to urban or rural areas in search of economic opportunities. These people typically do not have regular housing and pursue ad hoc jobs in either urban or rural areas away from their natal village. Several studies have been done on the challenges that face the floating population and also the quasi-communities and villages (often called peasant enclaves) established in urban areas by members of the floating population who originate from the same province (Ma & Biao, 1998; Solinger, 1999; Zhang, L., 2001). Migrant men

categorized as floating population are often married and have children. They typically migrate alone for the first few seasons before eventually bringing their families along. There is little known about the sexual habits and attitudes of men in the floating population besides the fact that these are the men who typically solicit sexual services from women who occupy the lower ranks of the sex worker hierarchy (Pan, 1999).

Construction workers (*jianzhu gongren*), on the other hand are usually young, unmarried and contracted by a construction company to work in the city. These men work long hours on China's vast construction projects in urban and rural areas. Men who work in the cities are often provided with housing in temporary buildings that are packed with bunk beds. In Beijing, these men are required to be in their bunks by 9:00 P.M., giving them little chance to explore the city considering their demanding work load. To date, there is no research on construction workers, but there is concern in Beijing about their vulnerability to HIV infection because of suspicions that they are either smuggling sex workers into the bunks or are having sex with each other when that is not possible. Most HIV/AIDS prevention projects to date have not addressed the needs of the estimated 120 million migrants currently floating around China, leaving both migrant men and women highly vulnerable to HIV infection.

Businessmen and local officials comprise an unofficial "high-risk" group in the construction of the Chinese epidemic, a population that is unaware of both their vulnerability to HIV infection and the potential role they play in transmitting the virus. A recent survey conducted by Pan Suiming of People's University in Beijing and Edward Laumann of the University of Chicago revealed that one in six men aged 25–29 regularly visit prostitutes. They also concluded that within the urban male population, men who hold management positions are ten times more likely than laborers to solicit the services of a female commercial sex worker, second wife or "sexual secretary" (Pan, 2001). A survey conducted by the Australian Red Cross in Kunming also found similar cause for the concern that wealthy businessmen are at a higher risk for HIV infection than is currently recognized. Female sex workers in Kunming identified male entrepreneurs as the most likely candidates for infection (Armajo-Hussein & Beesey, 1998).

It is almost commonplace these days to hear of men who frequent "entertainment establishments" (*yule changsuo*) like karaoke bars, saunas, beauty salons and massage parlors for massage, a hot sauna and the extra "entertainment" often provided in the back room. The young woman who calls up to hotel rooms late at night offering hair washing and massage (*xitou, anmo*) has also become ubiquitous in many large urban hotels.[1] Many businessmen are also finding ways to include trips to minority areas in Yunnan into their itineraries. Such a trip affords

them the rare opportunity to pursue a sexual experience with an exotic minority woman. Sandra Hyde has noted the disproportionate number of men on flights from Kunming to Jinhong in the Xishuangbanna Dai Nationality Autonomous Prefecture (Hyde, 2001). An increasing number of brothels are also popping up near the tourist village of Luoshui which sits on the banks of Lugu Lake in northern Yunnan. Men's curiosity brings them to Luoshui to have sex with Mosuo women who have been eroticized by tales of sexually liberal women who are not bound by restrictions of traditional Han marriage customs.[2]

Finally, research on male sexuality and HIV in China must consider the impact on identified gay men and other men who have sex with men. Although HIV/AIDS in the West was originally constructed as a "gay disease," the predominance of heterosexual transmission in developing countries (or so-called "Pattern II" countries) has caused international HIV prevention programs to concentrate efforts on messages directed at people infected through heterosexual contact. The dearth of HIV/AIDS statistics and sensitive nature of homosexuality in China make it difficult to give an accurate account of the infection rate among gay Chinese men and other men who have sex with men, but limited knowledge of the situation supports suspicions that HIV is affecting these men. In 2001, one-third of the patients at the AIDS ward of the You'an Hospital in Beijing[3] were gay men. A recent survey of 38 self-identified men who have sex with men in Beijing also indicated high risk for HIV infection (Choi et al., 2002). The gay community in Beijing is also the one community in China that has been able to unite around AIDS and create a cohesive group of local men who are working discreetly to promote HIV prevention. Condoms and prevention messages are passed around gay bars in Beijing. In addition, a gay AIDS hotline (The *Tongzhi* Hotline) was launched in March of 1997 and in 2001 the Ford Foundation provided Dr. Zhang Beichuan of the Qingdao Medical College with funding to start publication of a periodical called *Friends Exchange* (*Pengyou Tongxin*). This publication, which discusses issues related to gay life, sexuality and HIV/AIDS prevention, is distributed to thousands of men around China on a bimonthly basis. More research on homosexuality and gay men in China is still necessary, however, to respond to the needs of a community that is still developing while living in secrecy for the most part. Homosexuality in China is still heavily stigmatized, having only recently been removed from the list of Chinese psychiatric disorders (Chu, 2001). Most homosexual men still conceal their sexuality by conforming to Chinese social norms that expect them to marry and have a child. This dual existence introduces many questions about how gay men in China negotiate their sexuality. Additional questions need to be answered about what the notion of "gay" or homosexual means in a Chinese context and

whether and how it is influenced by globalizing trends of homosexuality (Parker, 1999; Carillo, 2002).

Research on Chinese male sexuality can obviously offer many important clues for future HIV prevention, but it is often argued that this type of research is methodologically unfeasible. Sex workers are usually aggregated in one area making them easy to locate. The clients of sex workers, however, are easily concealed because of their mobility. Clients of sex workers in many societies travel to a "red light district" to solicit sexual services and then leave immediately after a transaction is completed. In addition clients are usually identified with their primary occupation and not easily associated with sex work. The wide dispersion of clients makes it difficult to collect reliable epidemiological data that is dependent on a "representative sample" (Leonard, 1990; de Zalduondo, 2000).

Conditions in China are different however, where "red light districts" exist along side entertainment establishments that often cater to men seeking sexual services. Researchers who gain access to the karaoke bars, discos and beauty salons that cater to men have the opportunity to conduct participant observation and potentially interviews in these establishments. Anne Allison's ethnography of corporate masculinity in Japan illustrates the effectiveness of this methodology (Allison, 1994). It may also be possible to conduct clinical ethnographic research in one of the many clinics that care for the increasing proportion of Chinese men with sexually transmitted diseases. Pan Suiming, who has done pioneering research on sex workers in several Chinese locations, has most recently resolved the methodological dilemma of including men in his sample by inviting male participants into a hotel room where they can maintain anonymity (Pan, 2001; Parish et al., 2003). Another way to access information on male sexuality and masculinity is through women. Women's experience and views on male sexuality and masculinity are important to this type of research because gender is a social relationship that happens between men and women. Women also offer important contributions to the construction of masculinities. Matthew Gutmann's research on men and masculinity in Mexico City has shown that women's involvement in research on masculinity is "central and invaluable to any ethnography of men" (Gutmann, 1996, 1997b, p. 834). Gutmann also argues that masculinities have little meaning except as they are presented in relation to women. As such, it is important to interview Chinese women not only about their own sexual experiences but also about their impressions of the attitudes they believe contribute to their male partners' sexuality and their sense of being a man. The Australian Red Cross survey mentioned above was able to begin uncovering some impressions of male sexuality among businessmen through their interviews with female commercial sex workers in Kunming. Further

research of this type is necessary for delving deeper into the gendered interactions that contribute to the construction of men's sexuality and notions of masculinity in China.

Theoretically, research on male sexuality in China must be grounded within a Chinese context. An historical construction of male sexuality in China will be important for this discussion and such a perspective will distinguish Chinese sexuality from the dominant paradigms that structure Western theories of sexuality. Gender and sexuality in the Chinese context are greatly influenced by social status. Men who satisfied Confucian ideals of marriage and fatherhood in traditional China could be ascribed with male gender and were subsequently free to explore their sexuality outside of marriage without significant repercussions to their social status or manhood (Furth, 1988; Sommer, 2000; Brownell & Wasserstrom, 2002). Elite men who occupied the category of educated literati often pursued sexual pleasure through the use of erudite courtesan women who also served to increase these men's symbolic capital (Bourdieu, 1991). Many men also engaged in sex with young male catamites and eunuchs without any social repercussions (Sommer, 1997, 2000).

Wealthy businessmen in contemporary China also often rely on the powers of symbolic and social capital that can be accessed through beautiful women. In contemporary China, where market reforms privilege the patron-client relations of businessmen and local officials, an elite corporate male sexuality is operating within the realm of an "economy of desire" (Zhang, 2001). Businessmen use the symbolic power of their wealth to attract beautiful women who represent the type of social capital that was formerly reserved for men who occupied elite ranks in traditional China. And in a quasi-socialist Chinese state where political relations are also an important reservoir of power, businessmen curry favor with government officials by using their symbolic power to provide local officials with the services of beautiful women. We should combine the historical lessons offered to us from sexuality in traditional China with those of the more recent trends of sexual oppression that have created an important lacuna in China's sexual history (Yang, 1999; Zhong, L., 2001; Farquhar, 2002).[4]

These issues also raise questions about the connection of Chinese male sexuality with notions of masculinity. Previous anthropological studies of male sexuality that illustrate the cultural construction of male sexual desire and motivation are often shaped by paradigms of masculinity, where male sexuality is integral to cultural definitions of manhood (Parker, 1999; Lancaster, 1992; Allison, 1994). It seems important in the Chinese context to question this hegemonic view of masculinity and propose an alternative approach toward a culture of male sexuality that is linked to building social and symbolic capital (Bourdieu, 1983,

1991). At the same time, however, it is important for scholars of Chinese male sexuality to engage the new theories of masculinity emerging within the Western canon of male sexuality and masculinity. New discussions are recognizing that sexual and gendered binaries are not very useful, an argument that is important to discussion of Chinese sexuality and gender (Brownell & Wasserstrom, 2002; Gardiner, 2002). This new approach toward masculinity even considers that such a concept may be absent or at the very least structured differently in many societies and cultures (Connell, 1995; Parker & Easton, 1998). These new realizations within Western scholarship will help bridge the gap between theories of Western and Chinese sexuality by allowing scholarship that does not try to create "categories of maleness" (Gutmann, 1997a) where they do not conform to local cultural, historical and political economic factors. It will subsequently make room for theories of male sexuality that are not necessarily linked to local notions of masculinity. Finally, by limiting our reliance on binary constructions of gender and sexuality and hegemonic notions of masculinity we can facilitate our discussion and analysis of homosexuality in China. Reframing our discussion of sexuality and masculinity in this way will help us account for the political, cultural, and social limitations of a homosexual/heterosexual binary in China where public disclosure of homosexuality is still rare. The severe stigma related to homosexuality in China as a result of political discourse restricts homosexual men from revealing their sexuality. Consequently, the gay community in China is still very small, causing many homosexual men to live in isolation as well as fear. However, socially it is still possible for a man to live a dual heterosexual/homosexual lifestyle once he satisfies the duties of marriage and fatherhood. This dynamic poses challenges for those wishing to design HIV prevention messages for these men. One solution may involve focusing our inquiries into Chinese male sexuality on the political, social and economic processes and relationships openly shared by all men seeking sexual experiences. In addition, HIV/AIDS programs directed toward preventing infection among gay men or men who have sex with men should be adapted to address a society where men have multiple sexual "identities" (Connell, 2002) and inhabit environments where they can not or do not live as "gay men" (Linge & Porter, 1997).

More social science research is needed to design effective HIV programs that do not solely promote individual behavior change based on a framework of "high-risk" behavior patterns. Such programs promote stigma and discrimination against these "high-risk" groups and limit the reach of HIV prevention to specific populations while neglecting other vulnerable populations such as men who do not have sex with men or do not identify as such because of political or cultural reasons. This is one area that demands further research so we can design

HIV prevention programs that account for the cultural scripts and strategies (Carillo, 2002) that are influenced by the historical construction of Chinese male sexuality. Such programs will likely be more effective than the individual behavior change models that promote messages of safe sex, communication, and negotiation that are not informed by local cultural and social constructions of sexuality.[5] Effective HIV prevention programs will engage men's own perspectives on sexuality, help them realize their role as gendered beings, and ultimately their role in influencing the HIV/AIDS epidemic (Kimmel, 2000; Whitehead, 2001; Rivers & Aggleton, 1999). Most importantly, as Hector Carillo illustrated in his ethnography of male sexuality and HIV/AIDS in Guadalajara, social science research can help men realize their agency in interpreting local constructions of sexuality and thus their ability to contribute to a modification in the "rules of the game" as a means to effectively respond to the epidemic. Research on male sexuality and masculinity will offer valuable lessons for HIV prevention in China where a social hierarchy of urban, rural and migrant men shapes a complex sexual hierarchy that is constructed by China's unique historical, political and economic climate.

Endnotes

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1. This practice has become so common that some hotels now offer the option of turning off phone service after 10:00 p.m. and during *xiuxi* (siesta) period in the mid-afternoon, when young women are most likely to phone guests.

2. For more on tourism trends in the Lugu Lake district see Walsh (2001).

3. The You'an Hospital is one of two infectious disease hospitals in Beijing that treats AIDS patients.

4. Further discussion of the omissions in China's modern sexual history is beyond the scope of this short essay. Briefly, however, there is a gap in Chinese sexual discourse caused by Maoist policies that prohibited open sexual expression and discussion of sexuality. These restrictions, which began in the 1950s and were heightened during the Cultural Revolution, tried to erase all public discourse of gender and sexuality, including references used in everyday language like the terms man (*nanxing*) and woman (*nüxing*) since *xing* refers to sex. For further discussion see Zhong, X. (2000). *Masculinity besieged?: Issues of modernity and male subjectivity in Chinese literature of the late twentieth century.* Durham, NC: Duke University Press; Yang, M. M. (Ed.) (1999). *Spaces of their own: Women's public sphere in transnational China*. Minneapolis: University of Minnesota Press; Farquhar, J. (2002). *Appetites: Food and sex in post-Socialist China*. Durham, NC: Duke University Press.

5. For a detailed discussion on the limits of communicating foreign-designed HIV prevention messages to local populations see Pigg, S. L. (2001). Languages of sex and AIDS in Nepal: Notes on the social production of commensurability. *Current Anthropology,* 16(4), 481–541.

AIDS in China: Strengths and Vulnerabilities of the Gay Male Community

Robert Geyer

This topic, like any other, should be amenable to research. However, I am not aware of any surveys, studies, articles, or books that focus specifically on the strengths and vulnerabilities of the gay male community in the context of the AIDS epidemic in China. Given the increasing spread and severity of that epidemic, it might well be imagined that someone in China is in fact, in a scholarly fashion or otherwise, studying this issue. But, since no study has yet come to light, this essay is an effort to extrapolate from what I have read—and think I know—in such sources as do offer some insight on the topic.

The Homosexual Tradition

As a once-and-still student of history, let me begin by citing the hoary tradition of homosexual behavior in the Chinese literary and historical record. I hesitate to use the term homosexuality, let alone the "gay" word, in the context of this tradition, since these are largely constructs and labels of the last century or so and, as such, unhelpful in describing or attempting to understand the behavior of emperors, literati, opera performers, and other groups of men in the imperial period. For example, many—if not most—of the Chinese emperors since at least the time of the Han dynasty two thousand years ago seem to have had multiple wives and dozens of concubines as well as one or more male lovers. Therefore, to describe emperors as "homosexual" or even "bisexual" strikes me as being so simplistic as to be misleading. Yet there are so many stories of homosexual love between emperors and their male favorites in Chinese literary and historical accounts—and so many vestiges of these stories (like the "half-eaten peach" and the "cut sleeve") in the Chinese language today—that it is difficult to deny the

existence of an important cultural tradition handed down to gay males in China today. The same literary and historical record reveals far less about homosexual behavior among the *laobaixing,* the general population, of China over this long imperial period and, indeed, well into the twentieth century.

How important, then, is this tradition among gay males in contemporary China? Unfortunately (from my point of view), it is not important enough to constitute a strength of the gay male community as it faces AIDS in China today. For most of its history in power since 1949, the Chinese Communist Party and government has disdained almost everything old, including the kind of education that fostered familiarity with old China's literary and historical traditions. And students confronting a rapidly changing curriculum in the People's Republic of China's school system discovered quickly enough that studying scientific and technical subjects and learning their Marx and Mao were the most effective route to good jobs and party membership in new China. Education in the classics, then, although it did not drop out of the curriculum altogether (until the decade of the Cultural Revolution, at least), was seriously devalued, both by the Party and students eager to advance under the new system. By the time the Cultural Revolution had run its course in the late 1970s and Deng Xiaoping had restored a semblance of normalcy to Chinese higher education, there continued to be a premium on training in science and technology on the one hand, and on economics, commerce, and eventually law on the other. Although my reading of interviews in the 1990s of gay male Chinese who had been university students suggests that perhaps a disproportionate number of them studied history and literature (Li, 1996), it seems unlikely that more than a tiny minority of them—let alone of their less well educated peers—can have acquired much familiarity with a once-proud tradition of homosexuality in China's glorious past. I conclude that this tradition, though potentially a strength of the gay male community in China today, is of dubious importance as it faces the threat of AIDS.[1]

Coming Out of the Closet

Since the Cultural Revolution ended in the late 1970s, the politically and socially repressive environment for gay males in China—in the cities, at least—has eased considerably. To protect themselves against the political winds (including capricious charges of "hooliganism"), the snooping of neighborhood Party watchdogs, the threat of lost employment, the gossip of colleagues and friends, and the heartbreak of families, gays stayed in the closet. Although some observers have claimed that gays were evident among the many visitors to "Democracy Wall" during the "Beijing Spring" of 1979 (Wan, 1999), for example, it was not until the mid-1980s that gays felt comfortable enough to gather in public spaces

in Chinese cities—along the Pearl River promenade in Guangzhou, along the Bund riverfront area in Shanghai, and on the northeast corner of Tiananmen Square in Beijing. (This area was made famous, or notorious, not long ago in the film "East Palace, West Palace," with the palaces representing the public toilets just within the extended outer wall of the Forbidden City north of the Square.) Some twenty or so gays are said to have marched, with banners proclaiming who and what they were, among the hundreds of thousands of demonstrators in and near Tiananmen Square in May of 1989, before the crackdown (Wan, 1999). Throughout the 1990s, gay bars, restaurants, and discos appeared, providing needed space and venues for gays to meet and interact. Seth Faison, a *New York Times* reporter, visited a gay-owned-and-operated restaurant in Shanghai in 1997 and observed the many 20- to 30-year-old customers hooting with laughter at the campy lyrics and irreverent humor of a singer in drag. He quoted one of them as saying, "No one bothers about us anymore. As long as we're not disturbing anyone else, we can enjoy ourselves and the police will leave us alone" (Faison, 1997). John Pomfret, reporting for the *Washington Post* in early 2000, highlighted a very public wedding of two lesbians (Pomfret, 2000). It is easy to point to these developments and claim a sea change in the degree to which Chinese gays have come out of the closet. However, they belie the fact that, while gays may be out in increasingly large numbers to each other, they have by and large not come out to family, straight friends, and colleagues at work. For gay males, this is at least in part because many expect eventually to marry and have children, either due to a sense of obligation to parents and grandparents to carry on the family line or because their thorough socialization in Chinese culture has conditioned them actually to want a traditional family life even as they seek relationships with friends, sex partners, or lovers on the basis of their homosexual orientation. The *Post*'s Pomfret hints at this ambivalence of Chinese gays about coming out—one foot out of and one foot still in the closet—in the title of his article, "Among Chinese, a Low-Key Gay Liberation" (January 2000). In fact, the very term "gay liberation" seems a misnomer in the Chinese context, at least when we think of movements in the United States and Europe in the 1970s and even in Taiwan in the 1980s and 90s. Although cross-cultural comparisons are risky, it may be helpful to make them in examining the impact of and response to the AIDS crisis in China. In the United States, with the emergence of AIDS in the early 1980s and its subsequent development into a serious public health crisis, a very out-of-the-closet gay (and lesbian) community formed the core of "first responders" to the crisis, both as caregivers and as lobbyists for action at local, state, and federal government levels to confront and ameliorate it. In China, with so many gays half-closeted—still a large majority, I believe—it is difficult to

imagine their mounting as vigorous a response to the spread of AIDS in their country. A measure of this difficulty is the reluctance of even gay staffers of the AIDS Hotline in Beijing to emerge from the anonymity of the telephone receivers in their office to play a more public role in AIDS education and prevention (Wan, 1999). It is quite possible that gays in China find some (false) comfort, in comparison with their brethren in the early stages of AIDS in the United States and Europe, in the fact that they are not the primary risk group, ranking as they do behind drug users sharing dirty needles, prostitutes, and recipients of tainted blood transfusions as a source of concern, I believe, to multinational AIDS organizations if not also to the Chinese government. In any event, it does not augur well for arresting the spread of AIDS in China that the gay male community is still so relatively closeted and, arguably, not much of a community at all.

Looking to the future, however, it is conceivable that a more unified and identifiable community may soon emerge if two recent trends continue. First, greater political openness—both in terms of public assembly and freedom of the press—would grant a measure of security to gay organizations, including activist groups and businesses that serve gays and lesbians. Second, with greater economic opportunities in the coastal cities and the increasing mobility of the workforce, Chinese gays and lesbians—like their straight counterparts—may achieve greater physical distance from their families of origin. If the pattern of the U.S. movement holds, this greater physical distance could mean a partial, if not permanent, escape from family pressures and expectations. In this context, a freer, more independent gay community could evolve into a powerful force in the fight against AIDS.

Leadership

Even if we concede that gays in China—at least, again, in the major urban areas—are in fact coalescing into more of a community, where is the leadership to elevate its visibility and audibility to something approaching a critical mass? Currently, there is very little. The Chinese Communist Party and PRC government, even in the more relaxed political environment of recent years, have demonstrated a curiously ambivalent attitude toward homosexuality in general and its gay citizens in particular. For the most part, gone is the overt harassment of gays that characterized official policy or, rather, the thuggish implementation of such policy as there was, in the 1980s and early 90s. But would-be leaders of the gay community and even non-gay advocates of more sensitive, nuanced treatment of gays in scholarship, medicine, politics, and the media have been wary of adopting too high a profile, given government attitudes toward gays in

the recent past. An example of this wariness may lie among medical and mental health professionals, who have done much since the 1980s to help lift the taboo on public discussion of homosexuality. Most of these figures now appear to believe maintaining a low public profile is the prudent course of action, AIDS or no AIDS. Although some observers have criticized him on these grounds, Dr. Zhang Beichuan may be an exception. Zhang is the founder and chief inspiration behind a free, gay men's health and AIDS education newsletter titled *Pengyou Tongxin,* so called and translated by the editors as "Friend Exchange" apparently because each bi-monthly, 50- to 60-page issue includes several pages of personal ads. The newsletter, with funding from the Ford Foundation (U.S.) and Barry and Martin's Trust (U.K.), is a joint project of the Center for Sexual Health of the Hospital of Qingdao University College of Medicine (Zhang's base), the Institute of the Sociology of Sex of Renmin University in Beijing, and the Research Group for Mental Health of Taishan College of Medicine. (Qingdao and Taishan are large cities in China's eastern Shandong province.) The newsletter discusses homosexuality openly, advises gay men on how to practice safe sex, and outlines recent developments in HIV/AIDS research. It also contains personal stories of gay men in China, including those living with HIV. The newsletter is mailed to readers, mostly gay themselves, around the country, and is distributed at bars, discos, sports events, and other gay venues (Z. Lin, personal communication, November 17, 2002). Each issue of the newsletter has a print run of 8,500 to 9,000 copies, although Zhang estimates readership is much wider because initial recipients pass it on to other readers (Ruwitch, 2002). It must be noted, however, that most gay males remain unaware of this newsletter and of its important messages (Lin, 2002). Nevertheless, whatever his public profile, Zhang's role as driving force behind this newsletter is a significant manifestation of leadership in the face of the AIDS crisis.

Another, different kind of example—one providing perhaps even more hope—is that of Dr. Wan Yanhai, surely one of only a very few true "AIDS activists" in China. (See the interview of Wan Yanhai in this issue.) In the spring of 1992, Wan initiated the AIDS Hotline in Beijing, staffed by volunteers, many of them gay. At about the same time, he also launched "Men's World Salon," a gay meeting and discussion group. Initially, the salon lasted only a few months and the hotline barely a year (Wan, 1999), as the authorities seem to have feared putative assertions of a challenge to the government on the basis of human rights principles, or overtones thereof. The hotline re-emerged later in the 1990s and has been allowed to operate for the most part unhindered up to the present. Wan himself became a frequent contributor to a nascent public dialogue and debate over gay rights and AIDS education. This activity, or perhaps the up-front, out-

front way in which he conducted it, cost him his job in an office of the Ministry of Health. Perhaps also because of this, in more recent years he has traveled often outside China trying to make citizens, organizations, and governments in the U.S. and other countries aware of the threat of AIDS in China and of his own lonely efforts to do something about it at home, and to elicit support for a broader international program to combat the epidemic. Recently, in August of 2002, he was detained and imprisoned for a few weeks for allegedly releasing on his website evidence of the complicity of local authorities in rural areas of China in covering up the acquisition and sale of blood products tainted by HIV. The government of Henan province had shown antagonism toward Wan and his colleagues, who had helped organize infected farmers to fight for their rights and benefits (Lin, 2002). Some observers, both Chinese and foreign, claim Wan's arrest was a government set-up job. In any event, he was released after a brief but loud international protest, most likely supported internally by elements of the political leadership who believe that China must face up to the increasingly frightening scope of its AIDS problem, which is only exacerbated by attempts to silence those who advocate telling the truth about it as a necessary first step toward dealing with it. The obstacles that Wan, virtually a voice crying in the wilderness, has had to hurdle in conveying a needed message and in initiating quite benign action, are symptomatic of the difficulty of recruiting leadership for the fight against AIDS. This, then, is another vulnerability of the gay community in the face of the AIDS epidemic, and a particularly glaring one at that.

Official Attitudes

As the discussion immediately above I hope makes clear, official attitudes toward homosexuality and gays in China have contributed to the vulnerability of the gay community. Since the opening up of China, domestically as well as to the outside world, beginning in the late 1970s, the Communist Party and PRC government have at best looked on homosexuals with a jaundiced eye. Although there has never been any law against homosexuality or homosexual behavior in the post-Cultural Revolution legal code—perhaps a reflection of tolerance of these phenomena rooted in the imperial past—gays were often harassed and detained, and sometimes arrested and jailed, albeit usually briefly, under the charge of hooliganism, a catch-all term and relic of earlier PRC history (and a kind of crime not wiped from the penal code until October of 1997) (Wan, 1999). Through the 1980s and into the 90s, gays were targets of convenience with each passing political movement. I was able to observe this pattern while living and working in Beijing from 1985 to 1987, even though these years were relatively benign in terms of heavy-handed political pressure. Such a pattern of

harassment did not always affect the daily lives of those targeted, but some gays lost jobs and had to worry that record of a detention, for example, might find its way into their *dang'an,* or personal file, at the local public security bureau. In light of this capricious harassment of gays, it is small wonder that they collectively do not trust the authorities and are wary about coming out too publicly, let alone about daring to assume a position of leadership with regard to gay rights or AIDS prevention in the manner of Wan Yanhai.

I alluded earlier to a "curious" ambivalence on the part of party and government authorities toward the gay community in China today. Ambivalence, however characterized, is a relatively new development, and it would appear it has little to do with kinder, gentler, more liberal attitudes toward this minority and everything to do with the spread of AIDS and the threat that represents to the public health of the country. There are finally signs that Chinese officialdom is recognizing the enormity of the problem confronting them. It has not been edifying to see PRC authorities brought kicking, screaming, and protesting to this point, but, somewhat in their defense, it is a process that has been taking place since at least 1985, when the first HIV diagnosis in China (perhaps unfortunately, of a foreigner) was made. In the years since then, the government has had to acknowledge that AIDS is not solely a foreign problem, that homosexuality, prostitution, illicit drug use, and blood sales and tainted blood transfusions do exist, and that the problem has mushroomed from a handful of cases among non-Han drug users on Yunnan province's border with Burma to many hundreds of thousands of cases, perhaps even a million and a half. In the past few years, World AIDS Day has been observed, with television programs involving celebrities preaching AIDS education and prevention, which presumably reach tens if not hundreds of millions of viewers. Zhang Beichuan's newsletter has not been suppressed, and Wan Yanhai's AIDS Hotline has been allowed to continue operating. These steps do not amount to co-opting the gay community—indeed, are not necessarily targeted at it at all—but they do represent progress given the unenlightened attitudes and actions toward gays in the quite recent past. And, arguably, they even represent a grudging admission that the cooperation of the gay community is needed for the fight against AIDS. If this analysis is at all accurate, then it would suggest that—at least in this dimension of official attitudes and likely future policies—gays are lurching from a position of considerable vulnerability to one of modest strength.

A possible example of this emerging strength lies in the Chinese Association of STD and AIDS Prevention and Control. Since late 2000, the Association has recruited volunteers from the gay community to help promote AIDS awareness. Owners of gay bars in many cities have become members of the Association,

which has provided protection in the event the police find fault with the work of the volunteers. In December of 2001, gay community representatives were also invited to attend the first National Conference on STD/AIDS Prevention and Control, one of whose breakout sessions featured AIDS prevention. Further, gay health hot lines have appeared in large cities outside Beijing, such as Harbin, Dalian, Wuhan, and Guangzhou, although most of these operate only a few hours (6–9) a week and may not be publicized in the media, leaving their effectiveness a matter of serious question (Lin, 2002).

The Durability of Chinese Cultural Norms

Official attitudes and government policies, however, though certainly relevant, are scarcely the most important influence on the potential strength or vulnerability of the gay community in a culture as deep-rooted and a society as tradition-bound as China's, even today. Although it is true (and fortunate!) that Chinese culture has not been afflicted by religious tradition or dogma that purport to condemn homosexuality, homosexuals, and homosexual behavior, that does not mean that there is not misunderstanding of and prejudice toward gays. For one thing, there remains a legacy of Western scientific knowledge that began to penetrate China in the late 19th century—knowledge that, though more "advanced" than what existed in China at the time as regarded sex and sexuality, has long since been rejected as inaccurate and misguided. More importantly, because of the prescription of marriage and childbearing for all Chinese, gays risk flouting possibly the most fundamental norms of a family-centered culture and society. Even if most Chinese would not condemn homosexuality, homosexual behavior, gays themselves, or a gay lifestyle as sinful or wrong, as many Americans and other Westerners socialized in the Judeo-Christian tradition might do, they would, and do, describe these phenomena as *bu zhengchang*. This term, innocuously translatable as "abnormal," is frequently, cavalierly, and unthinkingly used by many Chinese to describe behavior they disagree with or people they see as different from themselves. In my experience it often connotes something approaching sneering contempt in Chinese. In other words, to most Chinese, since being gay is not the norm, it is beyond the pale and thus contemptible. It is perhaps for this reason that gays in China seem much more afraid that their families, friends, and colleagues will discover their truth than that Party and government policies may discriminate against them. It is also quite clearly for this reason that gay males in large numbers continue to marry and have children, either suppressing their natural sexual tendencies or, more likely, seeking gay sex and relationships outside of marriage and "normal" family life. Although the ploy of marriage followed by a quick divorce, thus bypassing the highly

complicating factor of a child and preserving future hopes for a gay lifestyle, including gay relationships, has become a more frequent, face-saving way around this problem, few gays apparently consider it an appropriate, let alone ethical, course of action. An even newer trend appearing in some large Chinese cities features a paper marriage between a gay man and lesbian, to satisfy parental and other family pressures in the short run, with the happy couple visiting their parents around the time, say, of Spring Festival but otherwise living separate lives (Lin, 2002). In sum, then, Chinese culture and society impose a culturally specific, heavy burden on gays in China, which creates different sorts of challenges than those faced by their counterparts in the West. In this regard, then, the gay community in China must forge its own path to overcome the crisis presented by the AIDS epidemic.[2]

Organization

Under the circumstances described above, it is small wonder that gays have been slow to organize or politicize. In reading interviews of gay males in Chinese cities in the late 1990s (Li, 1996; Zhou, 1996), one gets the overwhelming impression that, more than anything else, they yearn for a bit more (a lot more?!) space for living their own gay lives. Perhaps they are naïve in believing that they can achieve such a goal without following the road of politics and protest, as their comrades in the U.S. and Europe have done. But the scope for lobbying and political protest in contemporary China is clearly limited; the heavy-handed suppression of the Falun Gong in the last two years is sufficient reminder that PRC authorities, when they perceive a threat to stability or their own monopoly on power, cannot countenance even the most innocuous, benign attempt of a group to expand the scope of its activity as an actor in civil society. There seems, in the gay community, to be little energy or bravery to take on the system; rather, it appears the gay agenda is somewhat inchoate and focused on expanding opportunities for individual freedoms that would reduce the societal burdens they are forced to shoulder. If apt, this description of what gays most want in China today sounds more than a little self-indulgent, but from the vantage point of American or European civilization and society I find it difficult to criticize their agenda. Nevertheless, this is yet another characteristic of the gay community that positions it precariously to stem the tide of AIDS in its midst.

Naiveté About AIDS

Finally, the sheer ignorance about AIDS among gays seems unusually high, given the openness in China in recent years to news from outside the country and increasing access to it via the Internet and other sources. This ignorance is espe-

cially characteristic of, but scarcely limited to, the countryside, where gays are admittedly not the primary or perhaps even a very important risk group. Still, on top of all the other vulnerabilities of the community, this one is particularly alarming. The government's early denials of even the possibility that Chinese could contract HIV and subsequent partial, grudging retreats from that extreme position are largely responsible for the slow realization by gays and other groups at high risk for the virus that they could be threatened. Nevertheless, in the third decade of the worldwide AIDS pandemic it does not seem fair any longer to place blame on the doorstep of the government alone. Access to accurate information about AIDS—on the Internet, from official and nongovernmental sources, and in the mass media—should certainly be possible, if perhaps not routine, in at least the urban areas of China today.

In my opinion, it is not access to good information about AIDS, or even necessarily ignorance itself, that is the problem here. Rather, it is the reality that gays in China have been emerging from a period, decades long, in which they were not allowed the freedom to live their lives freely as gay men (or lesbian women). The most recent two decades of that emergence have coincided precisely with the world AIDS crisis, and Chinese gay men appear simply unwilling, or at least reluctant, to deal with the bad news that AIDS could compromise their freedom to live as they choose—to spoil their party. This may well be an unfairly harsh judgment to make on the entire Chinese gay male community, since there are undoubtedly many who protect themselves and others against HIV infection even if only out of fear, whether that fear is based on knowledge or ignorance. However, given the prevalence of Chinese gays' ignorance about AIDS and of their reluctance to accept—or outright denial—that it poses a serious risk for them, they are not now, not yet, in a strong position to help stop its spread in their own community or beyond.

Of course, the change in attitudes and retreat from safe-sex practices suggested by some recent studies of gay men in the U.S. paints an equally disheartening picture and bodes ill for the future of AIDS awareness in China. If the U.S. studies are accurate, they show that even in a society where information about AIDS is freely accessible, a misguided optimism in the efficacy of new HIV treatments has lulled a sizable group of people, especially young men, into complacency. In the worse case scenario, Chinese gay men who learn of these new medications could skip altogether the period of forceful—and effective—safe-sex education in the U.S. and come to view HIV drugs from the West as cures to an illness they are unlikely to contract anyway. Should this sort of cross-national mis-education prevail, the battle against AIDS in China will be even tougher.

The Uncertain Role of the Internet

This analysis would be seriously remiss if it did not acknowledge the explosion in recent years of Internet use in the gay male community. One long-time American resident of Beijing goes so far as to say that "Chinese gay culture today revolves around a number of gay Internet sites, and more people probably meet (and get together) through gay chat rooms than through face-to-face situations. I can't say how actively [the sites] work to disseminate anti-AIDS info, although I am certain there is some safe-sex info there. All the boys I have met recently [online] have indicated a certain degree of knowledge about the AIDS threat" (P. Laney, personal communication, November 25, 2002). Another observer, a PRC citizen who frequently visits China from his current base in the U.S., notes that "there are altogether hundreds of gay websites in China. Some of them publicize AIDS-related information, but they are quite wary of government intervention [on the grounds that they are] pornographic sites" (Lin, 2002). Both observers point out that these sites provide a venue for gay prostitutes, generally called "money boys," or *yazi* in Chinese. In fact, prior to the November 2002 Party Congress, during which it was apparently shut down, there had been a money-boy.com website, perhaps now up and running again. The American resident of Beijing believes such sites encourage boys who have gay tendencies to try to earn money from prostitution. He adds that "this might also provide a channel for the spread of AIDS which might not otherwise exist…I am now seeing a boy I met this way…I am trying to get him to give up this business, and his fear of getting AIDS is a major factor supporting that" (Laney, 2002). The Chinese citizen also draws attention to the problem of male sex workers, apart from their connection to the Internet. He says they "are not necessarily gay themselves, but [their] primary clients are homosexual men. These are young men in their late teens or early twenties, many from rural areas or other cities. They come to cities to seek a new life but have found prostitution to be the quickest way to make money. They frequent gay bars, bathhouses, open-air cruising areas such as parks, targeting gay men for possible trade. [Their] education level…is generally very low, as most of them barely finished junior or senior high school. Their first contact with the gay community is usually through anonymous casual sex, without the slightest knowledge of AIDS and safe-sex practice" (Lin, 2002). This phenomenon of male prostitution, aided and abetted by the proliferation of gay websites and likely accompanied by considerable ignorance about HIV/AIDS, is certainly a potentially serious barrier to arresting the spread of the epidemic and, as such, another major vulnerability of the gay male community in China.

Two Vignettes

In concluding, I would like to paraphrase the tale of a gay man counseled by AIDS activist Wan Yanhai from the early to late 1990s, as told by Wan in an unpublished manuscript dating from the year 1999. I do so not because I believe, or because I think Wan believes, the man's case to be typical, but it is one of the few vignettes I have unearthed that gives us in even moderately graphic detail a hint of how vulnerable the gay community in China, including both its "rank and file" and leadership, finds itself as AIDS threatens the country's public health. But, in order not to end on a completely pessimistic note, I would also like to quote part of a 1995 diary of a young gay man that seems to suggest a bit more room for hope.

> I met Li Qing in Beijing in the late fall of 1991 when I was a counselor at a mental health center and he came in for help. He had tried to commit suicide but failed. He hated his homosexual tendencies. He was sure something in the environment had led him astray.
>
> Li Qing told me that he was terrified of "those people" (the gay community) and felt their seductions everywhere. He was afraid to go out, so he stayed inside with the curtains drawn. He wanted to change himself but felt he was beyond hope. He had prayed for help in overcoming his homosexuality, but his god was homophobic and no help came. He hated all humankind. His mother was the only person worthy of his love. When we talked about responsibilities among people, he looked as if he'd never thought about it. Li wrote an autobiographical account called "Ghost Forest," describing himself and kindred spirits as "men by day, ghosts by night." He hated the police, because he had been arrested, thrown out of his home, and lost his job.
>
> I explained that AIDS is caused by the HIV virus, and we discussed the possibility of contracting the disease. He now realized that he belonged to a high-risk group. However, he said that he wasn't afraid of getting AIDS, because he did not want to live anyway, and that if he did contract HIV he'd go out and take revenge on someone else. He said that sooner or later he'd commit suicide but that he'd tell me first.
>
> Later, when I was in charge of the AIDS Hotline (April of 1992 to May of 1993), Li began to get involved. He attended group activities and forums on gay rights. He was interviewed by Chinese and foreign reporters, resulting in such articles as "Who Knows How Hard it is to be Gay in China?"
>
> During this period Li and I met often. Although he was still his old cynical self, I began to realize that something new was going on inside him. He no longer wanted to deny his homosexuality. There wasn't that same struggle between his feelings and his religion. On the other hand, it seemed that life had grown more difficult; there were continuing money problems, emotional strains, and trouble with the law.
>
> On June 10, 1995, Li told his story in a telephone interview with the Australian Broadcasting Corporation. He said that he was a male prostitute, that prostitution

was his livelihood. He cried while telling his story: he'd been arrested and labeled a homosexual, he'd lost everything—job, home, and face.

In 1997 Li called to say he had something important to tell me. By this time I had become more wary in this kind of work and was less inclined to go out and meet clients. Parents whose children had run away or attempted suicide in reaction to their homosexuality were after me. I was under investigation, and people had threatened to kill me. I had been through a lot. Li informed me he had AIDS and was receiving medical treatment. He said he wanted to commit suicide, then muttered, "If I go out and sleep with somebody tonight and he contracts HIV, is he going to think I screwed him over? I got it, didn't I? Who is there to stand up for me? Who's responsible for me?"

In Li's case, primary knowledge allowed self-recognition, but information externally acquired bolstered his inner longings. In years past, his homosexuality had been cause for fear, visits to the doctor, prayers to god, and suicide attempts. At the very deepest level, Li had been crying out from a sense of hopelessness. But in due course he began to accept his homosexuality and eventually was actually happy to talk about it. He became a participant in the social process of self-liberation.

Self-affirmation gave rise to political participation. He began to take part in social activities, made contact with the media, and participated in the gay liberation movement. He was emboldened to leave the closet.

Still, in important ways Li clung to his old passive mind-set, refusing to take responsibility for his own life or that of others. Aware of the risk of HIV, he nonetheless failed to take preventative measures; he rationalized that the virus was "passed on by society" and blame lay with others. When he actually did contract HIV, he said he wouldn't tell a partner, nor would he take preventative measures. If the other guy got it, "he had it coming to him." Li was simply "passing it back to society."

For Li, keeping some cards close to his chest was a way to express his deep-seated hostility to what he perceived as an unfair world. Having contracted the virus, he could get his revenge. This kind of passive-aggressive behavior was perhaps really an expression of rage.

Li Qing's story reflects the experiences and attitudes of a certain type of gay man living in Chinese cities today. And to some extent it reflects the psychology and background of the Chinese gay movement in general, particularly with regard to AIDS (Wan, 1999).

I Have a Dream—November 29, 1995

Today is Wednesday, and we comrades can see each other at the bar again. For the last six months or so, we've been going to the bar on Wednesdays, as if it's been a tacit understanding or secret agreement. Taking advantage of an opportunity tonight, on the eve of World AIDS Day, after getting the bar owner's permission, several friends decided to put up a small-scale AIDS propaganda exhibit in the bar. For quite some time I'd been collecting all sorts of AIDS-related materials from

various quarters, and just a few days ago I received two big boxes of this year's AIDS Day and related materials mailed by the World Health Organization. Two days ago I picked up from a government health unit nearly 1,000 copies of an AIDS propaganda flyer specially targeted at the gay community and several dozen posters. The picture and text on the flyer were really great. The picture is of a gay couple chatting and hugging in a park. This is unprecedented in mainland China, showing that the government, while concerned about the threat of the spread of AIDS, is also beginning to care about the existence of the gay community. The Western media frequently claim the Chinese government oppresses gays, but this is really a big misunderstanding. The biggest problem facing Chinese gays isn't some kind of government oppression, but rather popular ignorance and prejudice, which constantly strangle gays' vitality.

At ten in the evening, we took all the pasted propaganda materials and cut-up cardboard prepared over the course of the day to the bar. When we arrived, the bar was already full of people, sitting or standing, almost all comrades. After placing the cardboard in various spots, we put up this year's World AIDS Day theme posters proclaiming "rights for all, everyone taking responsibility," and distributed to every comrade the government-printed propaganda flyer.

The government has already begun to show its concern and propagandize accordingly, with the effect that the country now realizes AIDS is not just a "foreign import." AIDS is everybody's problem, and on the eve of World AIDS Day, as I stood before the exhibit I had personally arranged, I said a silent little prayer hoping that all people around the world would show a bit more tolerance and concern, and a bit less violence and fear, toward AIDS, toward gays, and toward other minorities enduring prejudice. Perhaps, in not too many years, a beautiful new world is not so "impossible." And gays are no longer just the opposite of non-gays, but have the common goal of mutually building a new China (Wu & Zhou, 1996).

Conclusion

Wan's account of his relationship with client Li Qing paints an undeniably bleak picture of one individual's vulnerability to AIDS. My own conclusions above with regard to the vulnerability of the Chinese gay male community as a whole in the era of AIDS are similarly bleak. However, since I draw these conclusions from a snapshot of the community taken in just the last few years, perhaps there is cause to be more optimistic about the future, with the account by Wu Chunsheng providing reason for such optimism. After all, the vulnerability I find with respect to the several dimensions discussed here represents a point on a continuum from extreme vulnerability to considerable strength, and the enormous and rapid social changes accompanying economic reform and restructuring in China today guarantee that another evaluation of this kind two, five, or ten years hence will be different, perhaps very different—and conceivably more hopeful. For example, the proud tradition of homosexuality in Chinese culture, with which most young gay Chinese have lost touch, lives on, as it has for the more

than two millennia since its recorded beginnings, and there may come a time when that record is more vigorously consulted. Similarly, even if most gays in China today remain in the closet, there is no question they are coming out in larger numbers than ever before, with the general relaxation in both social norms and political pressures. It's to be hoped that the Chinese government and Communist Party, precisely because of the threat of AIDS now all too obvious to them, will make common cause with gays and other at-risk groups to fight the epidemic with education, effective preventive measures, and a further lessening of oppressive political actions, as some signs suggest is already beginning to happen. And, as gays become more comfortable with the enhanced social space for living the kinds of lives to which they believe they are entitled, it is perhaps reasonable to expect that they will also test the boundaries of political activism and organize both to further their rights under Chinese law and to fight for their own lives and those of fellow citizens at risk for AIDS. This, in turn, should further break down their ignorance and insouciant attitude toward HIV and AIDS and bring forth more vigorous, new leaders in the fight against the epidemic. As with all the other earth-shaking changes taking place in China today, it will be critical, and clearly fascinating, to stay tuned and pay close attention to the course of AIDS and the evolving response to it of the gay community.

Endnotes

1. Indeed, if the experience of Taiwan in the 1990s is any indication, an historical awareness would not necessarily be readily utilized in the battle against AIDS. Despite a vibrant gay community—including leadership from writers, scholars, and artists—and a general awareness of homosexual traditions in Chinese culture, there is little evidence that gays in Taiwan have mobilized around such cultural traditions in their personal and social struggles against AIDS.

2. A study by Erni and Spires (2001) offers resonance for this observation in the experience of gays and lesbians in Taiwan: "Confucianism, or alternatively, 'traditional culture' (*chuantong wenhua*) is the ideological backdrop regulating social and political life in Taiwan. It is against the weight of a set of traditional, conservative cultural norms that the emerging political consciousness of the Taiwanese *tongzhi* must be understood. The stigmatization of queers in Taiwan, therefore, must be understood in its own context. Rather than the religion-based, class-inflected, or medically pathologized definitions of homosexuality in the USA, queers in Taiwan are marginalized through their fundamental deviation from the (heteronormative) traditional family-centred social order deeply informed by Confucianism. In this way, significant social change for queers in Taiwan requires a disruption of that traditional social order" (p. 41).

"When Riding a Tiger it is Difficult to Dismount":[1] Sexually Transmitted Infections in Contemporary China

Sandra Teresa Hyde

Introduction

The current epidemic of sexually transmitted infection in China provides a window to view the ways that globalization and commodification have transformed how Chinese bodies are sexed and sold, and how commercial desires converge in several epidemics. Once China opened the door to market socialism, the sex industry and the use of recreational drugs was not far behind. Once China had jumped on the tiger's back of development, it was difficult to jump off and slow the tide of rapid consumerism, commercial sex, and the rise of sexually transmitted infections and drug use that accompanied these changes. When I conducted ethnographic fieldwork on HIV/AIDS in Yunnan province between 1995 and 2002, many of my informants noted the increase in the commercialization of women's bodies, and the rapid rise in sexually transmitted infections (*xingbing* in Mandarin, and hereafter referred to as STIs) attributed to the dynamic changes in the Chinese economy since the late 1970s.

This paper does three things. First, it reviews the current situation in light of STI prevention and regulation since the late Qing dynasty (1860–1912), and briefly discusses the regulation and then the alleged eradication of STIs under the Communists in the late 1950s and early 1960s.[2] Second, it examines the social context of STIs, specifically how they are talked about in the border city of Jinghong in Xishuangbanna Dai-Lüe Autonomous Prefecture in southern Yunnan. Third, it concludes with a discussion of the current prevention efforts underway in Yunnan and provides potential avenues for further exploration based on suggestions of my informants. By combining a closer look at on-the-ground practices and the ways people's lives are affected by the current STI epidemic, one can recognize just how history repeats itself. It also becomes evident that

post-Deng China faces similar trials and tribulations that challenge other developing countries with respect to globalization and commercialization of sex and sexuality, and, most important, the increase in STIs like HIV/AIDS.

Talking About *Xingbing*

First, let's talk sex. I use several words to describe what are known as sexually transmitted infections in the West. As a caveat, when I present ethnographic information on HIV/AIDS, I do so with the understanding that STIs are surrogate markers for societal HIV risk; where STIs rise, so does the risk for HIV transmission. Second, I am looking at STIs as a co-factor for transmission. For example, genital ulcer disease increases transmission efficiency for HIV. And finally, addressing the prevention of STIs provides a potential public health model for reducing the spread of all other STIs especially HIV/AIDS.[3] According to Dr. Li Xiaoliang, a specialist in Preventative Medicine at Yunnan Medical College, the more common STIs in China include chlamydia trachomatis (*yituanti*); human papilloma virus (*renlei rutouzhuang liubingdu*) or simply warts (*you*); herpes simplex virus one and two (*danchunpao bingdu*) or simply herpes (*paozhen*); and pubic lice (*changbing*).[4] While these terms are rarely used in everyday speech in China, they suggest that China is confronting an STI epidemic similar to that of its neighbors in Thailand and Burma (Entz et al., 2001).

STIs from the Late Qing to 1964

In the late Qing dynasty (1893–1911), STIs were known as venereal diseases and often referred to as simply "sexual diseases" (*xingbing*). The most common STI was syphilis (*meidu,* "plum poison" in English). Gonorrhea, on the other hand, was referred to as *linzhuo* ("strangury") during the late Qing, and currently simply *linbing* ("dripping illness") (Dikotter, 1995). According to Kerrie MacPherson, Dr. George Thin observed in 1868 that Chinese doctors and scholars had identified venereal diseases with "some precision" by the late Tang dynasty (between 618 and 906 A.D.). The physician Tou Han Ch'ing noted that Chinese syphilography was intensively developed by the northern Sung (960–1279) (MacPherson, 1987). According to Dr. Tou, syphilis in China was first detected in Guangzhou. The Chinese were also the first to use mercury treatments for syphilis. After the establishment of the infectious disease act in Britain in 1866, it was extended to include Britain's concessions in China and the Shanghai settlement. While there was scant statistical data collected on the prevalence and incidence rates of STIs, there was a plethora of qualitative speculations about an increase in STIs (Watts, 1997). These arguments are important because they are mirrored almost 130 years later. STIs were believed to spread in Shanghai

due to several factors: 1) Shanghai was a seaport and attracted a large number of prostitutes within its limits; 2) it had a large floating population that brought in diseases from elsewhere (often the Japanese were blamed for the increasing incidence); and 3) its local female prostitutes were "the chief course of danger…who infested the settlement" (MacPherson, 1987, pp. 219–220). While Chinese xenophobia blamed the Japanese for infestations of STIs, among prostitutes it was the local Chinese who were blamed for the spread of disease rather than foreign prostitutes, who were thought to be cleaner and better attended. Edward Henderson, the Police Surgeon and Municipal Health Officer for Shanghai from 1870–1898, explored this subject in a report titled, *A Report on Prostitution in Shanghai*. His study was sponsored by the Municipal Council and published in 1871. It indicated that between 1865–1870 in the General Hospital, roughly 20% of the male patients were treated for venereal diseases (MacPherson, 1987).

Gail Hershatter (1997) notes that warnings about the dangers of STIs appeared in documents written for foreigners in Shanghai as early as the 1870s and were quite common by the 1920s. Based on data from several Chinese medical journals, Christian Henriot (1992) estimates that 10–15% of urban dwellers had syphilis and almost 50% had gonorrhea. Other occupational groups targeted as having high infection rates included 35% of the soldiers and policemen, 32% of the merchants, and about 20% of the general population. Of course, prostitutes were said to have the highest rates of all, and to be "the pestilent link in the chain of transmission" (Hershatter, 1997, p. 230; Sommer, 2000). According to Frank Dikotter, by the 1920s, venereal diseases had become a standard feature in Chinese reformist writings about prostitution and they were tinged with Social Darwinist overtones that suggested that, in fighting against prostitution, one was fighting for China's ability to survive. Dikotter notes that when the Nationalists unified China and established the Ministry of Health in 1928, "they lacked the financial resources and the political will to combat STIs effectively" (Dikotter, 1995, p. 137).

According to a handbook on the prevention of sexually transmitted diseases, after the Maoists took over in 1949, the new Communist government rehabilitated female prostitutes through re-education and re-employment programs centered around a Maoist-feminist analysis that labeled prostitutes' work as perpetuating the exploitation of women. Prostitutes did not hold up half the sky (*banbian tian*) (Fan, 1990).[5] By 1956, the Communist state closed the brothels and prostitutes were "liberated." According to a report on the country's development in the agricultural sector, every county was encouraged to eliminate STIs (Fan, 1990). Mao's military-like strategies to eliminate STIs began in 1950 under the guidance of the Central Research Institute of Dermatology and Venereology

(Cohen et al., 1996). This campaign was comprised of four key strategies: 1) training paraprofessional and public health personnel, 2) mass screening and treatment, 3) propaganda (health education, Mao-style), and 4) the elimination of prostitution. According to several articles published in China between 1959–1964,[6] STIs were allegedly eliminated through the efforts of on-the-ground socialist health care workers and the emergence of small anti-epidemic stations located at the county level (Fan, 1990). Even though by 1964 the Chinese state had allegedly eradicated all STIs, thirty years later they had made an exponential comeback at an almost terrifying rate due to changes in sexual consumption, patterns of tourism, and cross-border commerce.[7] However, almost no accurate statistics are available on the period in between from 1964 to 1985.

Sexually Transmitted Infections from 1985–2002

STIs in the 1990s have now overtaken tuberculosis to become the third most common category of infectious disease in China after dysentery and hepatitis B. The Center for Disease Control and Prevention in Beijing attributes this increase to changes in social mores since the introduction of market reforms in the early 1980s, the rise in promiscuity, and low levels of risk-awareness among ordinary people (AFP Newsgroup, May 6, 1999). In 1985, sex education was introduced into the middle school curriculum under the auspices of "adolescent studies." According to Geoffrey Cowley (1996), in the decade from 1984 to 1994, the southern island province of Hainan had a 170% increase in STIs largely due to the emergence of a local sex industry. According to Dr. Chen Xiangshan et al. (2000), the yearly incidence of STIs has increased on average about 17% per year since 1994, and extramarital infection remains the main source. In fact, at the "Health Care East and West" conference in Boston in June of 2001, Myron Cohen suggested that the highest risk group for STIs is wives of high-income businessmen whose husbands engage in extramarital and transactional sex (Cohen et al., 2001). The only infectious STI that has decreased since 1989 is gonorrhea, and that may be due to several factors: 1) changes in sexual behavior; 2) failure to give notification of gonorrhea because the disease is treated by general practitioners rather than gynecological and genitourinary specialists; 3) health-seeking behavior that leads to self-dose therapy; and 4) screening for syphilis in high-risk groups because syphilis is mandated in China's premarital examinations but gonorrhea is not (Chen et al., 2000). By the end of September of 2000, there were 800,000 reported cases of STIs in China with an annual increase of 30% over the previous year (Zhang, K., 2001). STIs are surrogate markers for societal risk for HIV (as rates for STIs rise, so does the risk for HIV). They are also co-factors for transmission, as the presence of STIs increases the

possibility of contracting HIV, with genital ulcers in particular (Choi et al., 2000).

STIs are not new to China or to the border regions of Laos, Burma and northern Thailand. As mentioned previously, STIs have a long history in China, a history that is tied to the waves of globalization and commercialization of the late 18th and early 19th centuries. Carol Benedict notes that bubonic plague traveled quickly through China from Yunnan province in the southwest to the eastern seaboard, and then northward; it was carried along transportation lines and among people building this complex transport system (Benedict, 1996). In post-Deng China, the proliferation of people moving both within and outside China has furthered the spread of STIs and the accompanying HIV/AIDS epidemic (which also began in southwest China in Yunnan province) (Beyrer et al., 2002). Since the rise in STIs is coterminous with changes in sexual behavior, I now turn to a discussion of China's sexual revolution.

The Contemporary Chinese Sexual Revolution

China is approaching its own "sexual revolution" in terms of individual behaviors that lend themselves to an exponential increase in sexually transmitted infections. According to George Wehrfritz (1996), China's "sexual revolution" has produced several casualties: divorce rates that are over 20% in some urban centers and a high rate of abortion among unmarried women (Nie, 1999). While divorce rates and unprotected sex are merely two symptoms of a Chinese public that no longer adheres to a Maoist regime of sexual conservatism, they also point toward the rise in new markets for abortions, divorce courts, and services for newly divorced singles. According to Ma Xiaonian, an expert at the National Institute for Family Planning, about 50% of all abortions are now performed on unmarried women (Wehrfritz, 1996). Wehrfritz also attributes the changes in sexual practices to the 1979 one-child policy, which in one sense "liberated sex from procreation," and "demystified the sex act" where modern methods of birth control (the IUD and sterilization) became widely available for the first time since the 1950s. This sexual revolution also allowed for what Chinese sexologist Pan Suiming (1999) describes as "the rise of fire out of the glowing embers" (*sihui furan*). While STIs and prostitution were allegedly eradicated after 1949, it was these smoldering embers that never went out that have allowed for a resurgence in contemporary STIs (Pan, 1999). I propose that one way to illustrate this is to focus on the social context of a small tourist town in southwest China's Yunnan province, the province that is ground zero of the Chinese HIV/AIDS epidemic. The town of Jinghong, the prefectural capital of the Xishuangbanna Dai-Lüe Autonomous Prefecture (*Xishuangbanna Daizu Zizhi Zhou*), has the reputation of

having a large sex tourism industry and is often referred to locally as a *piaocheng* (city of prostitution).[8]

The City of Jinghong and the Contemporary Social Context of STIs

In the early 1990s, southwestern China was beginning to look like other places in Southeast Asia with a growing HIV/AIDS epidemic resembling that in Thailand, attributed to a rise in injection drug use and prostitution (Cheng et al., 1996). The Mekong regional development area, made up of Thailand, Burma, Laos, and, now, southern Yunnan, became a region critical for understanding the traveling vectors for STIs and HIV/AIDS in what could be called the "golden quadrangle." With development and globalization have come a more unequal level of development and thus large-scale migrations of people, their accompanying goods and services, and new epidemics across geographic borders. In this "golden quadrangle," heroin trafficking has now incorporated the old Burma Road as a major access route through China, on to Hong Kong ports, and finally out of Asia to the United States and Europe.

Since few studies of HIV/AIDS in China provided qualitative data from an ethnographic perspective, in 1996 I went to the city of Jinghong to conduct fieldwork on the rise in prostitution and increased risk of contracting STIs, particularly HIV/AIDS. Jinghong itself is a semi-urban, multi-ethnic center surrounded by fertile river valleys and tropical forests that make it a popular Han Chinese tourist destination, and, more recently, a sex tourist destination. Like many global tourist destinations, Jinghong offers a rural fantasy world for those embarking on a journey there, and it presents a possibility of urban modernity for rural China (Tuan, 1998). The fact that brothels exist side by side with an active public security force means that even in Jinghong, where many locals and public security officers regard the brothels as a blight on the nation, brothels are profitable businesses in the emerging market economy.

In 1997, Jinghong had an official population of 140,000, but this statistic did not include the large numbers of migrants who work in the city. In the summer of 2000, locals estimated the population at closer to 600,000, including the people in surrounding suburbs of Jinghong county. As Li Zhang (1998) and Dorothy Solinger (1999) point out, the recent migration of China's large floating population (*liudong renkou*) has not only created a surplus of workers in small towns across China, but also many new informal small businesses. With increasing mobility and disposable income, Han Chinese tourists travel to Xishuangbanna to escape their work-a-day lives in the metropolises of Shanghai, Nanjing and Kunming. Although 90% of Xishuangbanna's tourists at the time of my study

were mainland Han Chinese, the immigrants were drawn from the wider Asian diaspora: for example, the Singaporean who cut hair in a salon owned by someone from Macao, and the Pakistani who traveled from Burma to sell precious jade. Moreover, migrant Han Chinese workers came from Sichuan to drive cabs, from Hunan to sell imported Korean clothing, and from Guizhou to run beauty salons (*meirong ting*) cum brothels (Qin, 1995).

In 1984, the two Dai-Lüe villages of Manting and Manjinglanix were not part of the city of Jinghong but were still independent villages not incorporated into the town. Grant Evans (2000) argues that, with encroaching development, by 1996 neither Manting nor Manjinglan were dependent on wet-rice cultivation, instead drawing much of their income from rents collected from Han migrants living below their houses built on wooden stilts. In 1995, Manjinglan was the major ethnic tourist area in Jinghong, and it was peppered with numerous Dai-Lüe-style restaurants that lined the main street. At night in the restaurant courtyards, one could view heavily made-up Sichuanese women dressed in faux Dai-Lüe clothing encouraging customers to enter their restaurants for faux Dai-Lüe dancing and food. What each restaurant incorporated was a mini-visual feast mimicking the Dai-Lüe New Year water-splashing festival—customers were sprinkled, and sometimes literally doused, with water after their evening meal. The young women who worked in these restaurants and dance halls often accompanied clients after-hours back to their hotel rooms for a price (see also Hyde, 2001).[10] The rise of a tourist-driven economy in Jinghong has paved the way for the marketing of sexual pleasure and desire, and the desire to exchange sexual services for money (transactional sex).[11] Nonetheless, with the arrival of sex tourism and prostitution comes a whole host of other problems, including an exponential increase in STIs.

Mao Zedong and "Prevention is First?"

At the end of the day, in dealing with any epidemic it is neither the epidemiology, nor what historical and ethnographic accounts reveal, that counts. What any epidemic begs for is Vladimir Ilyich Lenin's infamous dictum, *what should be done?* Although few prevention projects are mentioned in this short article, there are currently numerous efforts underway in China and in the remote counties of Yunnan, to prevent the spread of STIs, and more importantly, HIV/AIDS. While the Chinese state faces many obstacles to addressing the HIV/AIDS epidemic with full force, the current decentralization of provincial and county power means that in those counties where public health officials are eager to prevent HIV/AIDS, programs exist; whereas in those counties where public health officials are reticent, programs for HIV/AIDS prevention take a back seat to other

priorities (Dr. Emile Fox, Chief of UNAIDS, personal communication, August 8, 2000). In many geographic locales in China, very little is understood about the relationship between transactional sex and the spread of HIV apart from the speculation that women and men with many male partners are prone to infecting themselves, their clients, their boyfriends and husbands (Choi et al., 2000). In addition, the recent decline of China's public health system means that many people must fend for themselves in terms of accessing health care services. In a recent study, the World Health Organization claims that the equitable distribution of health care has declined dramatically in the past 10 years. Therefore, China has moved from a country rank of 144 to 188, due to the increasing privatization of health care and the uneven access to care among China's poor (Hilts, 2000).

The Chinese government was initially reluctant to support foreign NGO projects to build STI and HIV/AIDS peer education prevention programs for middle school and college students, and few resources are being directed at populations most susceptible to transmission, namely prostitutes, drug addicts, gay men, and migrant males (see Hyde, 1999, 2002).[12] Although I realize these classifications have been challenged by such cultural critics as Cindy Patton (1996), they do prove useful in drawing up schema that acknowledge that there are those more at risk than others for HIV. China is still within the limits of a country that follows pattern two countries, which includes countries with a high rate of heterosexual transmission, notably in Africa and Asia, as opposed to pattern one countries, which are those with a high rate of homosexual transmission and include the United States, Australia, New Zealand, and some European countries.

Preventing Sexual Transmission

All, however, is not doom and gloom in terms of prevention and the spread of STDs and HIV/AIDS. In a previous article (Hyde, 2000), I argue that when the power of the state and the power of the market compete, a fascinating paradox emerges. The market economy opens the door for the return of pre-1949 sexual practices; at the same time, it also provides a potentially strong weapon against sexually transmitted diseases and AIDS, namely the condom. In other words, I argue that the market in one sense allows individuals to side-step the state family planning apparatus by purchasing birth control through private vendors (department stores, pharmacies, small private sundry shops) rather than through state-sanctioned hospitals and clinics. Not only does the market open up a space for couples to gain access to birth control methods outside state-run clinics, but prostitution has brought a source of local tax revenues (Gil et al., 1993, 1996). Elizabeth Remick (1997) argues that during the Republican era some provinces

in China gained almost 50% of their tax revenues from a tax on prostitution (*jinu juan*). Pan Suiming notes that by the summer of 1998, over 43 cities in China had begun to levy individual income taxes on female sex workers (Pan, 1999). In addition, Pan makes the argument that since municipalities are now responsible for generating their own income, who could blame policemen for generating income by fining establishments engaged in prostitution—everything from karaoke bars, hotels, and restaurants, to escort services and massage and beauty parlors. Pan remarks that, in one town he studied, the locals had a saying about the police to the effect that some officials "whore when their trousers are off and clean up prostitution when their trousers are on" (Pan, 1999).

In the languid days I spent with sex workers in Jinghong, I recognized just when and where they would take precautions against HIV/AIDS. Similar to the Chinese government, they too placed AIDS firmly on the bodies of foreigners, specifically white foreign bodies; occasionally, they mentioned that they would not service Pakistani or Burmese men who worked in Jinghong who might too have HIV/AIDS. While condoms were plentiful in the shops in Xishuangbanna, Xiao Liu, a Jinghong pharmacist, noted that her male customers purchased cheap condoms and her female prostitute customers the expensive ones. When I asked prostitutes about this, they said they had more faith in the expensive brands, and that the Japanese and British condoms were the best. However, the underlying problem in all of these situations is that men—Chinese men, in particular, I was told—do not like to use condoms.

In San Francisco, Cianna Stewart, who worked with the Asian AIDS Project (now the Wellness Center), said that in conducting outreach with Asian sex workers in San Francisco, she discovered that prostitutes learned to put condoms on with their mouths without their customers knowing that condoms were being used.[13] Two well-known sex educators from San Francisco, Robert Lawrence and Carol Queen, were invited by Mary Ann Burris of the Ford Foundation in Beijing in 1996 to train educators and staff at Beijing's new Women's Health Center, modeled after the Boston Women's Health Collective. Queen and Lawrence demonstrated the ways that women can use their mouths to put on condoms. Pan Suiming (2001) states that prostitutes could be used as the frontline in promoting safer-sex education among their peers. The climate in both the brothels and other establishments where sex is exchanged could insist on a culture of condom use for all sex acts, as is the standard enforced practice in the state of Nevada in its 36 legal sex establishments (Schwartz, 2000).[14] In addition, more recent studies are beginning to show that microbicides may be a woman-centered method of prevention, as they can be used without the male partner's knowledge.

Conclusion

In drawing to a close, I wish to point out some of the limitations of this article. The statistics that I offer here should be taken with a grain of salt, as in all countries statistics can be used both to inflate and deflate certain social problems. In addition, the availability of hard data on STIs nation-wide is limited, and more research is desperately needed. While China is still in the early stages of its STI epidemic compared to its neighbors in Southeast and South Asia, recent sexual behavioral changes—what Kyung-Hee Choi et al. call "high prevalent multiple sexual partnerships, low condom use" (2000, p. 118), and STIs as co-factors of HIV infection—suggest that STIs and HIV/AIDS will spread rapidly. A timely response to developing STI and HIV/AIDS prevention programs is thus essential. To link the ethnographic representations of STIs to the on-the-ground situation means to create prevention projects that will alleviate suffering for all. In these efforts to reduce or curb the spread of STIs, China requires practitioners and public health professionals who understand STIs as infections that defy borders, ethnic groups, and identity politics within the late-socialist state. While acknowledging that globalization, commercialization and cultural politics play an integral role in how people function in their everyday lives, it should be remembered that STI prevention can work (some examples are Uganda and Thailand). To really prevent STIs at the level of everyday life means to slow down the tiger that the current wave of development and globalization has been riding, slow it down enough for the average Chinese citizen to be provided with adequate measures to prevent the further spread of STIs and HIV/AIDS.

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Endnotes

1. This is my translation of the common Chinese idiom *qihu nanxia*. Here I argue that "riding the tiger" aptly captures both the current exponential rise in STIs and is a metaphor for the difficulties facing public health experts in China.
2. Since there is relatively little information on STIs between the Republican era and the Communist revolution in the late 1940s, I refer sparingly to that period of history.
3. I want to thank Ann Williams for pointing out these concerns in her comments on this paper when it was first presented at the Yale-China conference in June of 2001.
4. The Chinese names for STIs were provided in consultation with Dr. Tong Huiqi, a psychiatrist from Shanghai, working in Boston.
5. The Chinese aphorism "holding up half the sky" (*banbian tian*) was a popular saying during the Maoist era. It represented the ideological commitment to promoting gender parity in Communist China. In the United States, in the late 1970s, the same aphorism was appropriated by liberal feminists but with the additional words, "and the laundry too."
6. For more citations and information on the eradication of STIs in 1950–60s China, please see Cohen (1996).
7. David Feingold (1998) in a recent study suggests there are high rates of trafficking in highland minority girls from rural villages in Southeast Asia into the more seedy aspects of the Thai sex industry. In 1995, I began my research with this premise in mind, but found limited evidence for the trafficking of Tai women from Xishuangbanna into Thailand when I was in Jinghong from 1995–1997.
8. *Sipsong Panna* (in Tai it means 12 rice-growing counties) was a former independent kingdom renamed Xishuangbanna Dai-Lue Autonomous Prefecture (Xishuangbanna Daizu Zizhi Zhou) under the Chinese state in January 1953 (Hsieh, 1995). Because of the neo-colonial slips between the geographic place of Sipsong Panna (the current word used by Sipsong Panna's Tais), and the Mandarin transliteration of Xishuangbanna, there are two different linguistic terms for the same ethnic population, Dai-Lue and Tai. The term Dai-Lue refers to the contemporary people who constitute the major ethnic group in Xishuangbanna Dai-Lue Autonomous Prefecture, an autonomous region in mainland China. Dai-Lue is also the Han romanization for the Mandarin character for Dai-Lue. The term Tai refers to the same people as an historical population in Thailand and it is the emic and respectful term chosen by contemporary Tais. According to anthropologist Charles Keyes (1996), though linguists quibble over whether the Tai people constitute twenty-four or twenty-seven distinctive ethnolinguistic groups, in 1980 there were close to seventy-two million people who speak Tai languages throughout Southeast Asia including the Dai-Lue-Lüe of China. The Xishuangbanna Tai part of the Tai-Kadai language family is a distinct ethnic and political group. Moreover to avoid confusion, I use the Mandarin term Dai-Lue or Dai-Lue-Lüe throughout this article.
9. Sara Davis (1999) notes that the contemporary Mandarin term Man is an inaccurate translation of the Dai-Lue-Lüe term Ban, so actually these names in Tai would be Ban Jinglan and Ban Ting, the old township names.

10. Across China, one of more well-known films on Dai-Lue culture is Zhuang Nuanxin's (1985) Sacrificed Youth (*Qingchun Ji*). The film, based on the novel "Such a Beautiful Place," by Zhang Manling, depicts a Han Chinese girl's sexual awakening among the Dai-Lue-Lüe of Xishuangbanna. She leaves her home in a large Han city to work among the Dai-Lue during the Cultural Revolution (1966–1977), thus becoming part of a Dai-Lue household and almost a daughter to the family, adopting their way of life. She proceeds to fall in love with a local Dai-Lue man. After relocating to another region to be a teacher, she learns that her lover has died in a mudslide. She then returns to her natal home grief-stricken about her former lover's death. What linger are her fond memories of his kindness and her own sexual awakening. For broader discussions of this film see Dru Gladney (1994). For a more thorough discussion of questions of gender and minority representation in China see Ralph Litzinger (2000), Louisa Schein (1999; 1997a; 1997b), and Erik Mueggler (2001).

11. There were rumors about the presence of gigolos (*mianshou*) in Jinghong. In a conversation with a Beijing businesswoman about my own experience with a harassing phone call, she explained that one Beijing official in Kunming received over 100 phone calls one night at a major Kunming hotel with solicitations from prostitutes. The official complained to the provincial tourist bureau, asking why this practice was allowed to continue.

12. Dr. Nagib Hussein, who did his medical training in Shanghai, was a pioneer in Yunnan and a maverick when it came to persuading the Chinese government to address the exploding AIDS epidemic. By 1995, Dr. Hussein was working for Save the Children (U.K.) and began a project in Xishuangbanna in collaboration with the city police and the Army's Drug Dependency Institute in Kunming to assist youth held in a local drug prison in reducing their dependency on heroin. The project set out to develop improved drug rehabilitation methods and to incorporate HIV/AIDS prevention and harm reduction education into the treatment process.

13. Cianna Stewart, a former outreach coordinator at the Asian Wellness Project, spoke to students in my Women's Studies course "Sexuality, Prostitution and AIDS," about some of the prevention tactics she learned from the sex workers in San Francisco (June of 1998).

14. Jay R. Schwartz (2000) went on a veritable sex tour in order to produce and publish the only guidebook to brothels in the state of Nevada. The information quoted here is from the introduction to his book titled, *The Official Guide to the Best Cathouses in Nevada: Everything You Want to Know About Legal Prostitution in Nevada*.

Reproductive Health Policy and Programs in China: Opportunities for Responding to China's AIDS Epidemic

Joan Kaufman

In China, the AIDS epidemic is expanding rapidly, and urgent action is needed to mitigate explosive growth that will occur if sexual transmission gains momentum (Kaufman & Fang, 2002). Until recently, China's AIDS epidemic has been concentrated among two primary risk groups: paid blood donors who acquired the infection from unclean blood collection practices, and intravenous drug users who share needles. The bridge for sexual transmission of AIDS into the general population will be China's booming sex industry. In the last five years, the sexual epidemic of HIV has begun to gather steam with worrisome rapid increases of prevalence among commercial sex workers regularly monitored by the national sentinel surveillance system and among gay men. This is especially so in China's southern and southwest provinces and probably in a number of interior provinces, fueled by high rates of sexually transmitted diseases, little or no condom use, and very low knowledge among the general population about risk behavior and vulnerability. Rapid sexual transmission of the AIDS epidemic from these two groups into the general population will be inevitable unless prevention programs are quickly extended to the entire country and populations at risk. The rapid spread of HIV will be fueled in rural China by large numbers of male migrants living temporarily in cities then returning home to rural wives, high rates of reproductive tract infections among these rural women, the low social status of rural women with no self perception of risk and little power to resist sex or negotiate condom use, and a huge population of young persons with little knowledge of safe sex. Women and youth are especially vulnerable populations because of low public knowledge of AIDS, low condom use, the nearly universal rate of marriage by gay men, the limited capacity of the weakened

health system to undertake the necessary prevention and care programs, and province-level stonewalling of needed action. Integrating AIDS prevention into reproductive health programs in China is therefore urgently needed.

Reproductive health entered the international lexicon during the early 1990s through the lobbying efforts of both the international feminist movement and advocates of integrated primary health care services for women dealing with matters related to their sexual lives. Feminists sought to bring increased attention to women's reproductive rights and more broadly to women's status in population and health initiatives. Sexual health argued that services for family planning, safe motherhood, and sexually transmitted diseases should be offered together for greater acceptability, efficiency and effectiveness. Under the broad umbrella of reproductive health, activists and scholars advanced a public heath agenda that would increase rights considerations and raise gender sensitivity in a number of previously separated health programs: maternal and child health, family planning, and sexually transmitted diseases (STDs) such as AIDS.

Attention to AIDS within the rubric of reproductive health has therefore focused attention both on women's vulnerabilities to the virus as a result of low socioeconomic position within their families and local communities, and also on women's vulnerability to sexual violence and HIV risk from non-monogamous partners or spouses. Toward that end, reproductive health programs promote the rights to sexual health services and information about safe sex. Within the health care system, reproductive health programs have promoted gender-sensitive STD services and also promoted men's responsibilities in reproductive health, offered services and education for youth, and advocated for HIV education, screening and treatment within family planning and maternal and child health programs. More recently, maternal and child health services have become the vehicle for offering services to pregnant HIV-positive women to prevent infection of the offspring.

Major turning points for linking prevention and control of HIV/AIDS with the larger agenda of reproductive health globally and for China in particular were the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995. China was a signatory to the Platforms of Action adopted at these two meetings, and in the years since Cairo, China has initiated a number of health and family planning programs that conform to the priorities of these initiatives and integrate efforts to respond to the HIV/AIDS epidemic within reproductive health services. The ICPD included AIDS prevention and control as an important item in newly defined reproductive health services (UN Population Fund, 1996). In the nearly ten years since ICPD, an impressive number of reproductive

health programs have begun in China, and national policies on health and family planning are being revised to comply more closely with the ICPD Platform for Action.

Like most countries, China faces problems of bureaucratic coordination in integrating HIV/AIDS care within the existing health care system. But in China the situation has been particularly problematic because of the division of responsibility between the State Family Planning Commission and the Ministry of Health. While the issue of re-integration of services has been raised repeatedly, the matter has not really been dealt with at the national level because of the highly political nature of the population program. However, several pilot programs and projects within the family planning sector, the Chinese participant to ICPD, have incorporated recommendations from the ICPD action plan such as youth outreach, increased attention to the diagnosis and treatment of reproductive tract infections in women, and the incorporation of AIDS prevention information into improved counseling within family planning programs. The health sector has likewise instituted pilot projects for the prevention of mother to child transmission of HIV/AIDS and outreach to sex workers. These programs will be discussed below.

Youth Reproductive Health

An important issue highlighted at Cairo in 1994 was the need to reach youth with reproductive health information and services. In China, adolescent girls and boys and unmarried youth have had very limited access to either information or services for family planning or safe sexual practices. Strong cultural norms prohibit discussion of sexual matters with unmarried youths and have contributed to resistance to including young people in HIV/AIDS prevention programs or providing them with access to contraceptives and condoms and information on their use. This, however, is changing as Chinese society, especially in urban areas, begins to acknowledge the huge change in sexual norms and behaviors of young people and the deadly potential risk of unprotected sex. The huge number of young people in China—over 200 million between the ages of 15–24 (State Statistical Bureau of China, 1995)—makes the potential impact of high HIV infection rates among youth a frightening prospect. Sadly, in Chinese provinces where HIV has been around the longest, youth aged 15–30 had the highest HIV rates, repeating similar trends from other countries in the world where HIV infections among youths or acquired as youths aged 15–24 constitute about half of all new adult infections (UNAIDS, 2002).

A number of studies in recent years have provided ample evidence that Chinese young people's attitudes and behavior towards sex are changing. Studies

in Beijing, Shanghai, Tianjin, and Chengdu have documented that youths believe that premarital sex is acceptable, and that increasing numbers of young couples, especially those intending to marry, do engage in premarital sex (Cao, Zhang, & Zhang, 2000; Li et al., 1998; Chen, Cui, Li, Luo, Tian, & Xie, 2000). Unfortunately, these young people have little HIV/AIDS or contraceptive knowledge, and over 50% do not regularly use contraception (Gao, Tu, & Luo, 2000; Li et al., 1998). Data from Shanghai reveal that over one-third of abortions in one hospital were performed on unmarried women (Gao et al., 2000). Age at sexual debut is still late compared to other countries and numbers of partners still remain few, and these factors may protect China's youths. Even so, the need for accurate safe sex information and easy access to condoms remains essential.

Official policy has now begun to change and recent meetings sponsored by the State Family Planning Commission have called for increasing information and services for youth about safe sex. The China Family Planning Association, the Chinese affiliate of the International Planned Parenthood Federation, has begun a major project to address youth reproductive health needs with international donor support. In Yunnan province, the Australian Red Cross and China Red Cross Society have run very successful school-based peer HIV/AIDS education programs for many years. Recently this project has been expanded to several other provinces and could serve as a national model. Nevertheless, as in other countries, there are well organized opponents to providing sexual health information to young persons or promoting condom use for safe sex, some of whom have been funded by the "religious right" (e.g. the Unification Church) to promote "abstinence only" programs that are misleadingly labeled as sexual health education programs (Wan, 2000). Intervention such as this has created confusion among those seeking standard curricula and guidance on how to conduct sex education for youths, creating an urgent need for the central education authorities to provide high quality sex education curricula for school-based and out-of-school programs and for family planning authorities to extend services and information beyond married couples to all young people.

Reproductive Tract Infections and HIV risk

High rates of untreated reproductive tract infections (RTIs) among China's rural women make them vulnerable to HIV infection from returning migrant husbands infected while working in cities. A community-based study of over 2,000 women in rural Yunnan in 1995 revealed high levels of RTIs (Kaufman, Yan, Wang, & Faulkner, 1999). Over 50% of women were diagnosed with an RTI (20% with candida, 16% with trichomonas, 15% with bacterial vaginosis, and 5.5% with chlamydia), and many women had two or more concurrent infections.

Tri-chomonas, although classified as a sexually transmitted disease in the West, is considered by the Chinese medical community to be caused mainly by poor hygiene. These high rates of gynecological infections, especially trichomonas, put rural women at increased risk for HIV transmission. Epidemiological studies have estimated the increased risk of HIV transmission to women with trichomonas as four-fold (Wasserheit, 1991).

Most women with RTI symptoms are too embarrassed to see a doctor; indeed, less than 20% of women with symptoms of RTIs seek care for the symptoms at regular health facilities (Fang, 2001). However, even if women routinely sought care at local clinics, the rural health system is usually unable to make a differential diagnosis or treatment. RTIs are routinely only classified as either vaginitis or cervicitis, with no pathogen identified, and treated inappropriately (symptomatic relief for vaginitis and laser therapy for cervicitis). Most women seek care from traditional doctors without a physical exam, requesting medicine for their symptoms (*xiashenyang* or lower body itching). Several of the standard remedies are highly marketed traditional drugs with unknown efficacy; others are douches or preparations made of various Chinese herbs which may alleviate symptoms but probably do not treat the underlying pathogens.

Some efforts are underway by both health and family planning service networks to address the RTI issue. While the Maternal and Child Health/Primary Health Care Department of the Ministry of Health has not yet taken up the issue as a national program of work, a large World Bank/DFID project (Health 8) to develop a model for basic rural health services has included RTI diagnosis and treatment as a priority service intervention and is developing protocols for service delivery and health education materials, including promoting male responsibility. The State Family Planning Commission (SFPC) has now included attention to RTIs in its service requirements for rural women. SFPC is devoting resources to document and address the high levels of rural RTIs through the family planning program. SFPC is also developing service protocols and approaches for improving the asepsis of its facilities and for diagnosing and treating RTIs as part of routine family planning services. RTI diagnosis and treatment are part of a larger effort to improve the quality and client needs focus of the national family planning program (Zhao, 2001). Confusion remains, however, among senior Chinese family planning program managers about the applicability of WHO's STD diagnostic algorithms for use among women, especially the classification and management of trichomonas as an STD rather than as a hygiene-related infection.

Public Education about HIV/AIDS

Public knowledge about AIDS remains low among China's citizens. In a survey of over 7,000 individuals in 2000 conducted in seven counties by the State Family Planning Commission, 20% had never heard of AIDS, over 73% did not know how it was caused, and over 80% did not know that HIV could be transmitted by sharing a needle or by mother to child transmission (Cheng, Mo, Yan, & Zhang, 2002).[1]

There are few propaganda and information infrastructures in the world with the technological capacity and reach of China's family planning program. This infrastructure has reached every resident in every village of China in the last twenty years with the family planning message and could easily be deployed to undertake HIV/AIDS education and prevention as well. While past audiences for family planning have primarily been adult married women and couples, there has been an extension in recent years to rural labor migrants living in urban areas. These audiences all require HIV/AIDS education and prevention, as do young persons both in and out of school.

Preventing Mother to Child Transmission of HIV/AIDS

In recent years it has been demonstrated that a single dose of the drug nevirapine given to pregnant women shortly before giving birth, and to the newborn shortly after birth, can prevent up to 95% of cases of mother to child transmission of HIV/AIDS if no breastfeeding occurs. This simple drug regimen is now recommended by WHO, and earlier protocols using AZT are nearly as effective. While nevirapine is not currently available at affordable prices in China, a generic domestically manufactured version of AZT is now available in China at greatly reduced cost (Rosenthal, 2002).

While reported cases of mother to child transmission of AIDS still remain low in China, they are expected to increase as the epidemic continues to expand to the general population and to young women. In Henan province, there are already many HIV-infected children born to mothers who donated blood at paid blood donation stations, and in provinces like Yunnan and Sichuan, with pockets of generalized long-term epidemics in places like Liangshan and Dehong prefecture, more and more cases of mother to child transmission are reported. At present, other than small pilot projects carried out by UNICEF and Médicins Sans Frontières in Henan and elsewhere, none of these places have begun systematic programs to prevent mother to child transmission of HIV/AIDS. Given the current constraints in health financing and the quality and reach of local maternal and health services, especially for preventive activities, the prospects of implementing universal mother to child transmission AIDS prevention programs in China remain slim in the near future. These constraints are discussed below.

Commercial Sex Workers as the Bridge Population for the Sexually Transmitted Epidemic

In the years after the 1949 revolution, prostitution was virtually eliminated in China. But over the last twenty years, there has been a huge resurgence in prostitution throughout China. Official data on arrests from the Ministry of Public Security state that there were over 580,000 individual arrests of prostitutes from 1981–1991 (Chang, 2002). That number increased to 420,000 in 1996 alone (UN Theme Group, 1997), but estimates of those engaged in sex work are closer to four million. Because prostitution is illegal in China and arrests and incarceration are common, China's sex workers are an underground population hard to reach with AIDS prevention information and services.

Much of the commercial sex work in China is "informal" sex work, in the Thai style. This involves low-paid workers in beauty salons, barber shops, coffee shops, karaoke bars, and massage parlors who are also available for sexual services for a price, and *sanpei xiaojie,* or "three accompanies" girls, who act more as escorts but who also sell sexual services (Pan, 1999). There is very low AIDS awareness among these sex workers outside of major cities, and condom use is at best inconsistent. Rates of sexually transmitted diseases are high, with up to 10–60% of sex workers in detention testing positive for a STD (UNAIDS, 1997). Up until recently, HIV infection has remained low among sex workers, but recent data from Guangxi and Yunnan revealed that these rates are climbing rapidly. In one sentinel surveillance site of sex workers in Guangxi, 5% tested positive in the last quarter of 1998 and the rate increased to 10% in 2000. In Yunnan province, the rate increased to nearly 5% in 2000 (UNAIDS, 2002). A recent report by Horizon Research in Sichuan and Yunnan revealed that over 15% of commercial sex workers in Yunnan and Sichuan also engage in intravenous heroin use (Yuan, 2002).

Who are the clients of these sex workers? Many assume that the main clients of sex workers are male members of China's huge migrant labor population who temporarily live and work in cities away from the social constraints of families and villages; no doubt these men do pose a risk of spreading HIV to home communities and their wives. But recent published data from a large national sexual behavior survey reveal that the main clients are middle class men less than 35 years of age (Parish et al., 2002). In rural areas, officials and businessmen are 10 times more likely than manual laborers to buy sex, and in rural areas 22 times more likely. Men with income in the highest 5% were 33 times more likely than those in the bottom 40% to have bought sex (Pan, 2001; Cohen et al., 2003). Many of these sexual transactions take place as part of business transactions, to clinch contractual agreements, or as a new form of traditional client patron relations and power exchanges (Uretsky, 2002).

Unfortunately, until recently, neither condom use nor other HIV harm reduction measures have yet to be widely promoted by health authorities outside of pilot project areas. There has been reluctance among some health authorities, most notably a senior official in the National Health Education Institute, to promote condom use for fear that it will endorse promiscuous behavior (Zhu & Gao, 2000). A condom advertisement appeared briefly on television in 2000 promoting condom use for STD prevention but was quickly withdrawn by censors. This ambivalence in promoting condom use has been unfortunate for AIDS prevention efforts in China. A State Council meeting on HIV/AIDS in December of 2000 finally endorsed condom use for AIDS prevention, and the Medium Term Plan for HIV/AIDS prevention and control revised in April of 2001 included for the first time both condom promotion and distribution of clean needles to intravenous drug users as official harm reduction activities to be promoted. But there has not as yet been any national public AIDS awareness campaign or condom promotion effort other than in localized pilot projects such as WHO's 100% condom campaign among selected groups of sex workers, which was modeled after a similar effort in Thailand. Likewise, outside of pilot project areas, mainly in southwest China, there is little access to "best practices" which have reduced transmission among this high risk group in other countries such as promotion of clean needle strategies (needle exchange, bleach and cleaning education, etc.) or drug substitution (methadone) for preventing HIV transmission among intravenous drug users (National Institutes of Health, 1997).

Constraints: Health Service Privatization

One of the largest challenges to implementing needed HIV/AIDS prevention and care programs in China is the weakened state of the country's rural primary health care system after two decades of privatization. Years of under-financing and consequent deterioration in service quality and reach have all but destroyed the previously impressive primary health care system, especially its health education and prevention services. Reaching populations in need of HIV prevention and care through this weakened structure will thus be difficult.

Fiscal decentralization in the early 1980s severely limited financial subsidies for social services, including health care, from higher administrative levels to lower ones (Carrin, Aviva, Yu, Wang, et al., 1997). The health budget as a percentage of GDP in China has never exceeded 4–5% and is below this level in many poor rural counties. The Ministry of Health is among the weakest at both the national and provincial levels in vying for extra-budgetary funding. Since fiscal devolution and the dismantling of the commune system in the late 1970s and early 1980s, privatized fee-for-service health care has become the norm in

rural villages; the Cooperative Medical System (CMS), financed through a combination of commune welfare funds and small private donations that covered over 96% of the rural population through the late 1970s, reached less than 12% of the population by the end of the 1990s (Carrin, Aviva, Yu, Wang, et al., 1997). Preventive services and public health education have suffered in many poorer areas since health providers spend their time in income-earning activities and poor communities are unable to sufficiently subsidize salaries of outreach workers (Saich & Kaufman, 2001). The weakened capacity for health education and the poor reach of current maternal and child health services in rural areas make it unlikely that the primary health system can undertake the needed work of HIV/AIDS prevention and care, including the work of preventing maternal to child transmission.

National and local level data provide evidence of these problems. A survey conducted in five rural counties in Yunnan in the mid-1990s showed that in the poorest townships, only 5% of women received in-hospital deliveries and, of those delivering at home, only 17% used modern delivery practices. The remaining 78% of women gave birth at home attended by a relative or friend. These low rates of hospital and safe home delivery are confirmed in other studies from throughout China (Fang, 2001). In the Yunnan study, self-reported reproductive morbidity during pregnancy or resulting from delivery was high. For example, many women reported symptoms consistent with hypertension of pregnancy as well as instances of serious vaginal tearing during delivery, but rates of prenatal care or health seeking for these problems was low (around 17% of those reporting problems). The major reason women did not seek care was their lack of knowledge that they should, strong evidence that the breakdown in health education in rural areas is impeding the use of health services for preventable morbidity (Kaufman & Fang, 2002).

The crisis in funding for local level health services has intensified a debate which began in the early 1980s. At that time, the recently formed State Family Planning Commission began to separate family planning clinical services from health services (Kaufman, Zhang, Qiao, & Zhang, 1992); previously, family planning had been a sub-unit of maternal and child health services and delivered through the health care system. By 2000, the separation of services was nearly complete, with over 500,000 family planning service stations set up at county and township level throughout China with over 400,000 staff (B. Zhao, Director of Division of International Cooperation, personal communication, 2001). These new facilities, well maintained and equipped with trained clinical personnel, are underutilized. Many have been built with higher-level subsidies supplemented by local special taxes. Meanwhile, the local health service facilities are

deteriorating and under-staffed. Many question the efficiency and ethics of maintaining separate service facilities for health and family planning in the poorer areas, where public funds are limited, and are now advocating a re-integration of resources and services for poor local women.[2] This debate obviously is framed by the political reality and perceived national importance of the family planning program and the reluctance of the government to do anything to undermine its success in controlling population.

But this debate may escalate as the resource-strapped health system increasingly must deal with the burden of clinic-based AIDS prevention (mother to child transmission programs and voluntary testing and counseling) and treatment of AIDS patients. At the moment, health facilities in rural counties, townships, and villages not only provide little AIDS prevention education, testing, or counseling, they also rarely offer even palliative care for the opportunistic infections that plague most AIDS victims. AIDS patients are highly stigmatized and health workers often refuse to treat them for fear of contracting the disease due to ignorance of how to protect themselves from accidental exposure. Re-training China's huge corps of medical workers at the local level in humane and appropriate care for HIV/AIDS sufferers will be expensive, even before the costs of laboratory testing or provision of antiretroviral drugs are taken into account.

In 2002, the Chinese government moved to allow the domestic manufacture and sale of antiretroviral drugs, greatly reducing the cost of AIDS treatment (Rosenthal, 2002). AZT is now being manufactured locally, and two other drugs used in the AIDS cocktail will also soon be manufactured domestically. While these drugs remain too costly for most rural AIDS sufferers, China's recent submission to the Global AIDS Fund includes a proposal to provide treatment to hundreds of thousands of sufferers in central China and to provide voluntary testing and counseling. Such proposals were unheard of as late as 2001, at which time treatment and treatment access were never raised as part of the needed government response to AIDS. It is heartening to see how quickly the right to high quality counseling and care has become a central part of China's planned AIDS response.

Conclusion

This paper has reviewed the prospects for sexual transmission of HIV in China and the opportunities and constraints in using reproductive health programs and services to address AIDS prevention and care for rural women and youth. China is at an important crossroads: timely intervention to prevent the spread of HIV/AIDS can still spare millions of potential victims in China from the fate of their counterparts in sub-Saharan Africa, and there are institutional practices that

may allow China to piggyback HIV/AIDS programs on China's existing reproductive health services. However, there are also signs that the current health system may not be able to maximize these opportunities.

China's family planning propaganda infrastructure is unique in the world in its ability to reach every citizen in the country. The State Family Planning Commission has signaled its interest in deploying this infrastructure for HIV/AIDS education, and is in a stronger position to do so than the Ministry of Health's health education system, which has been weakened by years of health privatization and under-funding and restrained by conservative officials opposed to condom promotion.

Belated, but now increased, attention to the prevention, diagnosis, and treatment of women's reproductive tract infections by both the SFPC and MOH will be important mechanisms for preventing widespread transmission of HIV to China's rural women. These efforts should be promoted and expanded, and should include HIV prevention information and risk assessments; they also could provide opportunities to reach rural women with voluntary HIV testing and counseling services. A recent report on the huge increase in HIV infections among rural women in India pointed out that ten years ago these women were not considered to be at risk. A similar fate awaits China's rural women in the years ahead unless prevention programs begin now.

The problems set in motion by the privatization of health services impede efforts to provide needed AIDS prevention and care in poor communities. As with the problem of insuring safe delivery to the rural poor, the deteriorated and under-funded local health services will find it difficult to respond to the health care needs posed by communities decimated by HIV-infected patients. The central government therefore must increase spending on subsidizing critical health needs of the rural poor and reach out to vulnerable women and youths with AIDS prevention and care programs if the worst case scenarios of the AIDS epidemic are to be avoided.

Endnotes

1. This study was conducted as a baseline survey for a pilot AIDS education project to be carried out by the Commission's Information, Education and Communication Division.
2. Open Discussion (2000). "Conference on China Rural Health Reform and Development," China Health Economics Institute and the Institute for Development Studies, UK, Beijing.

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The Role of NGOs: An Interview with Wan Yanhai

Argyro P. Caminis

Dr. Wan Yan Hai is one of China's few and foremost AIDS activists. Through creative community-based outreach activities, he has built a network of activists and volunteers in ten Chinese cities to support HIV/AIDS education projects in China. In September of 2002, he was able to officially register his organization, the Beijing Aizhixing Institute of Health Education, with the government. The organization operates out of a Beijing office with two full-time and a handful of part-time staff members. What began in 1994 as a project with limited resources has now become one of the few Chinese non-governmental HIV/AIDS education organizations. In this interview, Dr. Wan talks about the development of his organization and the challenges and benefits to working outside of the government system to fight AIDS in China.

APC: Some experts in the field of AIDS prevention and control have argued that progress in combating AIDS has come only with strong involvement from civil society. In your opinion, will this be a key factor in combating HIV/AIDS in China? How so, or why not?

WYH: In the long-term, I believe the government should work together with civic organizations. But you have to look at the short-term realities. The Chinese government has far greater capacity and dramatically more resources than do non-governmental organizations in China, particularly in the field of health. NGOs can play a valuable role in monitoring how people are treated and how the government publicizes information, but most NGOs don't have access to surveillance information and therefore cannot see the complexities of a given infectious disease. So in the short term, I think we must rely on the resources of the Chinese government while continuing to strengthen community-based groups.

APC: Is there more room for non-governmental organizations to operate in society now than there used to be?

WYH: Although China has a one-party system, the political environment has changed throughout the 1990s. These changes have affected the role non-governmental organizations can play in China's fight against AIDS.

In the 1990s, our goals were to educate people, provide people with information and encourage people to connect and organize with one another. But by the late 1990s, because of the Internet, because of the existence of more NGOs and the involvement of more people in the so-called development of civil society, we found that these goals were not enough. People asked for more. In the mid-1990s, for example, we would be very sensitive about writing the term "human rights." By the late 1990s, people were proud and open in talking about human rights. Talking about human rights is not enough anymore; now, people are organizing themselves to fight for human rights.

APC: What do you think prompted that change from the mid- to the late 1990s?

WYH: The Internet, time, international attention to the crisis, the human rights and democracy movement—all of these factors pushing for change in China have had an impact on the development of China's NGO sector.

APC: What role do you envision for community-based organizations in fighting against the spread of HIV/AIDS in China?

WYH: We can do some things that the government can't do: we can work in the community, we can speak directly, and we don't need to be politically correct. NGOs and community-based organizations can work in those areas that the government doesn't want to touch because of legal barriers, moral conflict, bureaucracy or corruption. We can cross legal barriers and work with marginalized populations like drug users, sex workers and migrant workers. We connect the people to the government, and the government to the people. NGOs are also a way to attract international funding. In the future, I think NGOs will be able to organize demonstrations for political reform. I hope that I can organize some demonstrations in Beijing—not now, but maybe in the future. And we will ask the government for approval, of course. I think it's important that NGOs also call attention to the government's responsibility to provide care to patients and services for prevention and education.

APC: What is the status of community-based groups supporting AIDS care and prevention in China now?

WYH: In the current situation, we don't have strong civic institutions to support AIDS care or prevention in China. NGOs struggle to survive because of the difficulty in attracting trained professionals. Most professionals, particularly in the field of health, work for the government. Sometimes with the help of international funding, we've been able to hire professionals and program managers, but this hasn't been available to all NGOs.

Most so-called "NGOs" are government-organized and government-directed. Some such groups we call *huapings* (flower vases) because they look good but don't have much function. The problem is that these kinds of ineffective groups get funding and support from the government, and as a result, act as barriers to the real support groups.

APC: What has been constructive in engaging communities to address AIDS?

WYH: Government support for community-based action against AIDS is still limited. However, there have been positive steps towards increasing this support. In some cities like Shanghai and Chengdu, HIV patients have won legal battles for compensation against wrongful infection. In Henan, the government is allowing various community-based AIDS advocacy groups to register as organizations. These are promising changes. However, the government still only allows limited community participation and supports groups with goals matched closely to that of the government.

At the Beijing Aizhixing Institute of Health Education, we have organized support groups for people with AIDS. I've found that sharing information has been a powerful tool in building communities. You have to give people information so that they can develop ideas. Information about health, prevention and treatment, legal issues and discrimination is all very helpful. When people share information, they're also sharing friendship…and they will eventually organize. It is quite a natural process. It takes time to develop trust and open communication, but after time, people grow together and understand the importance of organizing themselves.

APC: Can you tell us more about the nature of the Beijing Aizhixing Institute of Health Education? For example, what kind of organization are you?

WYH: Aizhixing is an independent AIDS education, research, policy/advocacy and care organization. As of September 27, 2002, we have been officially registered as an "enterprise" with the Beijing Industry and Commerce Administration Bureau. By independent, I mean that we don't have an affiliation with any sort of government institution or so-called "mother-in-law" organization. Furthermore, we raise funds by ourselves and develop our stance on issues based on our own independent research. Currently, we have two full-time staff members in the Beijing office. One is the executive director. The other is an office assistant. We also have a part-time accountant, a part-time staff member working on the website, some student volunteers, a lawyer, and a fellow who does scholarly and research work. We have a board committee of just over ten people, all Chinese, and most are located in Beijing.

APC: Where does your financial support come from?

WYH: We started as what was called the "AIDS Action Project" in the early 1990s. At that time, we were affiliated with an educational institution and were able to secure grants from a foundation in the U.S. and from individual donors within China. Since then, we've received grants from international funds, private and public foundations abroad, grants from foreign governments, and individual donations from donors in the U.S., Canada, Taiwan and Hong Kong. We have tried to reach some foundations in China, but these efforts have failed. We have no funding from the government. If we don't have good relations with the government, it's difficult to solicit funds from Chinese donors because people will be concerned that we are a progressive group pushing for social reform. They will worry about having a financial tie to this kind of institution. It's always a problem—to get funding, you'll have to be less radical. I think that's even a problem in the U.S.

APC: How would you characterize the relationship you have with the government?

WYH: The relationship with the government is changing all the time. In the mid-1990s, we sent our research to the Ministry of Health so that the government might benefit from our work. We tried to provide information and teach them about AIDS, sexuality, and health and human rights issues. But the Ministry of Health is very bureaucratic. They haven't responded to us in the past ten years! No phone calls, no emails, no letters.

I believe that it is very important for us to work with the government. I think that the government should offer more support to NGOs. As an NGO, we are marginalized in China. We need money to work, and maybe our government could create grants for NGOs. Support from the Ministry of Health, for example, might also help us to establish working relations with other institutions.

APC: What is the focus of Aizhixing's work?

WYH: We are still trying to define our efforts. At a board meeting in January, we discussed the kind of work we could do in the future. Some ideas were to work on legal aid issues, orphan support, education programs, policy and advocacy. At this moment, we are focusing on small-size programs to create collaborations with other organizations and increase our own capacity and expertise. In the short term, we will work on several education programs and research programs. But in the long term, I anticipate that our group will work as a kind of advocacy and research organization.

APC: What have been your strongest influences in becoming an activist?

WYH: A lot of people have influenced my work, but I think it was I who directed my own orientation. If I were to point to any one person, I would point to my father as one of my great influences. I learned a lot of lessons from his generation. Although they have terrible memories of the communist revolution, they also have a long history of fighting for the people. That idea influenced me a lot and has been my basic orientation and direction—this has never changed. I don't like the revolution in any way, but the spirit of struggling for equal rights and for the people is something that drives my work.

I also read a lot and talked to all kinds of people. When I was studying public health, I would read books on philosophy, anthropology, psychological counseling, research methodology, newspaper articles and journal articles from the World Health Organization. Through these, I came to understand the link between AIDS and human rights. When I was working for the government, I would meet regularly with representatives from Australia, Canada, the U.K., France and the U.S. for lunches and dinners. They would bring information from the Gay Men's Health Crisis, from community support networks in Canada, from organizations working for prostitution, the World Health Organization, and some foundations. And also some Chinese scholars, such as Professor Chu Renzhong at the Chinese Academy of Social Science, shared some very helpful ideas and thoughts about how to address China's epidemic.

APC: Have you sought other NGOs as models for your own organization?

WYH: We try to work in a traditional Chinese style. We try not to be confrontational, but sometimes we decide to choose a strategy that is safe, reasonable and rational. Supporters of mine outside of China have said my work follows the tradition of Confucius. We are like Chinese-style intellectuals—not trying to challenge but rather trying to help the government. In China, the government and public think I'm too radical and too confrontational. I hope they will come to see us as rational helpers.

We try our best to utilize traditional ways, but we are also open to using learning strategies from other countries. In 1990, we didn't have much information about AIDS. I was in touch with individuals in Hong Kong and Taiwan who were starting to get involved in social and public advocacy. In the late 1990s, when a lot of people got connected through the Internet and email, we had more contact with one another and other organizations outside of China. Some well-known human rights and AIDS organizations such as ACT Up have influenced our work.

I'm working with some NGOs in the U.S. now and I like the way NGOs are structured here. People understand responsibility, they understand rights, and they talk and argue with one another. This fall, I will enroll in a program on NGO management to better understand how to direct an NGO to work democratically and efficiently.

APC: What kind of support and partnerships do you have with organizations within and outside of China?

WYH: We have a lot of contacts around the country, both in and outside of the government. We have some connections with hotline services in Shanghai for gay and lesbian communities and we're supporting some groups in Henan and Guangzhou. We don't have relations with the Ministry of Health, but we do have affiliations with some local health departments, community clinics and health centers. We have become a member of the China AIDS Association and the Global Health Council.

We've had contact with foreign governments and also with some international NGOs for the purpose of increasing our capacity and raising funds. For example in March, my colleague was invited to a meeting in South Africa for international solidarity and in April, we sent representatives to Thailand for a harm reduction program. Later this month, my colleague will attend a French AIDS festival of solidarity. We also have contact with groups in the U.S. such as

the Yale-China Association and a group that I meet with regularly in New York and Philadelphia to define strategies and programs to push for change in China's approach to the AIDS epidemic.

APC: What have been some of the challenges and difficulties you have faced as an NGO in China?

WYH: It has been difficult at times, but we have made progress. In the late 1990s, the political situation became more tolerant of AIDS organizations working in the community. The public was more willing to talk about human rights and AIDS issues. There were people with AIDS who spoke out and publicly campaigned. But in those years, there were few activists working on AIDS issues in China and most of us worked independently; we didn't have an established base, a regular flow of resources, and it was difficult to register as a non-governmental organization.

Maybe in the future, if there are more NGOs and activists in China, I will be able to take greater risks with my work. But currently, it's not an easy voice to have in China. Our position is difficult because if we push too much, then we risk losing our registered status; if we adopt the voice of the government, then our role becomes meaningless. I believe we need to be both a critic and a friend of the government.

NGOs in the U.S. or Thailand, for example, don't have to worry about being detained by the government. The government doesn't have a reason to stop them for AIDS activities. But in China, our government worries about how people will organize themselves. AIDS activism involves a lot of social organization, so if the Chinese government continues its policy towards NGO development, the role of NGOs in China will remain quite limited.

The Legal Dimension: An Interview with Jonathan Hecht

Deborah S. Davis

Jonathan Hecht is one of this country's leading authorities on contemporary Chinese law and an important scholar of Chinese criminal procedure. Before becoming Deputy Director of The China Law Center at Yale Law School, Mr. Hecht worked in the Beijing office of the Ford Foundation and taught Chinese law at Harvard Law School. He has more than ten years experience as a program officer and consultant on legal reform projects in China with the Ford Foundation, the United Nations, the U.S. State Department, and other organizations.

DD: Given your extensive experience of working in legal reform in China, which legal issues do you see as paramount in addressing the HIV/AIDS epidemic?

JH: There are of course many different legal issues relating to HIV/AIDS in China, but the one that I see as in some ways most fundamental is how the idea of nondiscrimination takes on a real legal life. The idea that people with HIV/AIDS should not be subject to discrimination is reflected in national policy documents and local laws, but there are other things in these policies and laws that are in tension with that idea. For example, many of the approaches that are being used in China to address HIV/AIDS—such as forced quarantines and various coercive measures against high-risk populations—are at odds with or undercut the idea of nondiscrimination. There's also the problem of the absence in the Chinese legal system of any effective way to seek recourse if one is subject to discrimination. For example, a lot of people have been talking about the rules that

were adopted in Suzhou last fall as a step forward in protecting the rights of people with HIV/AIDS because they provide concrete remedies, but I think that's actually far from clear.

DD: Could you say something more about the Suzhou regulations? *The Suzhou regulations can be viewed at the following website: <www.law-lib.com/law_view>.*

JH: A number of cities in China have adopted local rules on controlling and preventing HIV/AIDS, sometimes together with sexually transmitted diseases (STDs). That's actually an interesting fact in and of itself—that HIV/AIDS and STDs are being lumped together as similar problems. In Suzhou last fall, a set of regulations on HIV/AIDS was adopted and a number of groups in the West were initially very positive about them, mainly because they made a strong statement of principle that people with HIV/AIDS should not be subject to any type of discrimination. But when you look at the specific measures that these regulations call for in dealing with HIV/AIDS, there's still a lot of emphasis on quarantine, forced testing, things that can easily undercut the notion of nondiscrimination. And the Suzhou rules and Chinese law more generally lack very clear ideas of what discrimination is—how you define it, how you measure it—and lack concrete remedies that people who feel that they've been subject to discrimination can pursue. This is common in a lot of different areas in China—women's rights, children's rights, minority rights, many different areas where China for a long time has had a general norm of nondiscrimination, but where the legal system hasn't developed corresponding ideas about what actually constitutes discrimination and what one can do if one suffers discrimination.

DD: Does that mean that this idea of discrimination comes from outside of China? Or is the problem political?

JH: I don't think that the idea comes from outside China. Sometimes there's an outside influence; for example, there may be relevant international standards or China may be a party to an international treaty that contains norms of nondiscrimination. But I don't think that these are ideas that, at the level of political theory anyhow, are antithetical to the ideas of the ruling elite. They're not contrary to Party ideology. The bigger problem has been that the political system and legal system don't provide mechanisms by which one can vindicate one's rights other than when the state chooses to do so. What I think you see in this area—and it's not unique to this area, but in some ways it's particularly obvious—is that in many ways the Chinese legal system remains something to be used at the dis-

cretion of the state, the discretion of bureaucrats, rather than something that can be activated by people who feel that their rights have been infringed. Often there are provisions whereby people who feel that their rights have been violated can go to a government official and seek some sort of redress, but whether anything happens remains in the discretion of the government official. I think as China becomes a more diverse society and less of a bureaucratic society, that old system of redressing rights violations is becoming less and less viable, while at the same time people's own sense of their rights is becoming stronger and stronger.

DD: I'd like to return to your statement that the concept of discrimination and the right not to be discriminated against have a basis in the Chinese context, and may become a force for fundamental change in legal practice. Could you expand on that?

JH: I think part of the function of the norm of nondiscrimination is to serve as a force for cultural change. Often such norms are adopted over time while there's still a lot of resistance in the society. There has to be enough of a social basis for the idea to be adopted to begin with, but in the HIV/AIDS context, if the Chinese government as a matter of policy has accepted that the best way to reduce transmission is through education, voluntary testing, and treatment, then nondiscrimination would be a very important piece of that effort. They would have instrumental reasons, policy reasons for adopting an idea of nondiscrimination and also policy reasons for using the legal system as a way to increase acceptance of that idea in the population as a whole.

DD: Do you know any of the history behind this Suzhou legislation?

JH: I don't know the history of the Suzhou legislation. Again, the reason that I flagged this is that many other aspects of these regulations, whether in Suzhou or at the national level, are working counter to this general norm of nondiscrimination. On the one hand, you are saying you want people in society to understand that there's nothing blameworthy about having HIV/AIDS, but on the other hand you're saying that if you have HIV/AIDS you're going to be quarantined. So the message is a mixed one. Likewise, if you want to use the idea of nondiscrimination in a popular education sense, then there's the question of what is an effective demonstration of one's ability to vindicate that right. If reliance continues to be placed on the traditional system of enforcement at official discretion, then I think under current conditions in China, it may not be terribly effective. These rules, like rules on nondiscrimination in a lot of areas in

China, are not structured, and the system is not structured, in a way to put the power of initiation and of vindication in the hands of the person who suffers the discrimination, which tends to be a more efficient way of actually seeing that principle take on a life.

DD: Do you know when this language of legal protection against discrimination began to be relevant in the PRC?

JH: You first see it on a significant scale in the late 1980s and early 1990s.

DD: What groups were addressed at that time?

JH: In the early 1990s, two national laws were adopted, one on the rights of children and one on the rights of women. This is another interesting comparison with HIV/AIDS in that there's no doubt that one reason why these laws came out relatively early in China's process of accepting the idea of rights, is because there were bureaucracies that represented children and represented women. There's a youth federation, there's a women's federation, but there's nothing comparable for people with HIV/AIDS. This raises the question of who speaks in the Chinese system for people with HIV/AIDS? It's very clear who speaks for women, it's very clear who speaks for children. Whether they truly represent the interests of women and children, whether there are other voices that aren't being heard, are of course open questions. But they have a bureaucratic presence, and in the Chinese legislative system that's extremely important.

DD: As she notes in her paper in this issue, Joan Kaufman has also emphasized that one constraint on effective medical response to HIV/AIDS is the weakness of the Ministry of Health. In other words, HIV/AIDS patients are disadvantaged because they have no strong bureaucratic advocates. Would you agree?

JH: Yes. I'm not sure that the MOH has to this point seen advocacy for the rights of ill people as a significant part of its mission. In the women's federation especially there was always an emphasis on protecting women's rights and interests, sometimes in a very paternalistic way, but that was an element in women's federation ideology in the very early days of the women's movement in China, before the revolution.

DD: In the U.S. we do not support rights to health care as does the Chinese Constitution. Do you think therefore that in this way the socialist experience has created an advantage for the Chinese as they deal with HIV/AIDS epidemic?

JH: I think that's right on the level of ideology. Article 45 of the Chinese Constitution suggests people have a right to health care, but like all economic, social, and cultural rights in China, as well as many other types of rights, this idea remains at the level of aspiration. There has never been a detailed definition of what that right is, or any set of procedures and institutions that could be relied on to realize it in practice.

China often emphasizes its superiority as far as economic and social rights, but I don't think anyone could seriously argue that in present day China people do in fact enjoy those rights. Education and health are two areas where equal access or equal rights are, if anything, becoming less likely.

DD: To return to the Suzhou regulations, do you think that this type of legislation might help to expand the rights of the ill in general, or will it be confined to the specific case of HIV/AIDS patients?

JH: The Suzhou rules are limited to HIV/AIDS and STDs. But there is something in the political ideology in China that legitimates the right to health care, and that's not true in the U.S. And that can be used in China as an argument for why the HIV/AIDS problem should be addressed in a particular way. But HIV/AIDS is also a stigmatized disease and that's why I come back to the question of whether the legal system can strengthen the idea of nondiscrimination not merely in an abstract way, but in a way that would actually help to address effectively the HIV/AIDS problem on the ground.

One thing that may strengthen the social basis of the principle of nondiscrimination is that many of the people in China with HIV/AIDS have contracted it as a result of behavior that almost everyone would consider non-blameworthy. People who have contracted HIV/AIDS because of blood sales, blood transfusions, or mother/infant transmissions are not people who would be viewed as blameworthy in anyone's eyes in China. So it may be that there will be less social resistance to the idea of nondiscrimination against people with HIV/AIDS.

If we turn to the high-risk behavior to which blame does more often attach—prostitution and drug use—it's interesting that neither is technically a crime in China. They are both illegal, but China, unlike most countries, has a distinction between crimes and illegal behavior that to some extent parallels the idea of felonies versus misdemeanors or infractions, but in some ways is very different. This may be another instance where China may be in a position from a legal point of view to look at these issues differently than other countries because of this distinction between crimes and illegal behavior in these high-risk groups.

DD: For the general readership, can you say more about how something is legal but not a crime?

JH: Crimes are defined by the Criminal Law. To some extent this is a formalistic distinction, but it has very important practical consequences. Under the Criminal Law, organizing prostitution or coercing someone into prostitution is a crime, but being a prostitute and even an individual act of prostitution are not crimes. There is no article in the Criminal Law that defines those as crimes. Likewise, the sale of drugs, the manufacture of drugs, the transport of drugs, and the smuggling of drugs are all crimes and they are dealt with extremely harshly, but the use of drugs is not a crime. Now, possession of drugs is a crime and one might ask in how many instances will one simply be a user and not a possessor, but again, there is a distinction drawn between use of drugs and possession of drugs.

The fact that use of drugs and prostitution, as well as soliciting a prostitute, are not crimes does not mean that one can engage in them without any punishment. They are subject to a different set of sanctions. China has other laws, including the Security Administration Penalty Rules and the vague set of standards relating to Reeducation Through Labor, that state that these are illegal behaviors and provide for various sanctions. The practical consequences are that one who engages in prostitution, solicits a prostitute, or uses drugs is not dealt with through the criminal process. Instead they are dealt with through a much less open administrative process controlled by the police. From the offender's point of view, there is a positive side to this—one doesn't end up with a criminal record. Chinese who believe that this distinction should be maintained often state that this is a more humane way of dealing with these sorts of problems than treating these people as criminals and giving them a criminal record which will follow them for the rest of their lives. That's part of the rationale behind this distinction. On the other hand, there are also negative consequences, mainly that the administrative process affords offenders fewer rights and tends to be much quicker and less open than the formal criminal justice system.

This is a little outside of the immediate topic, but there is also a general principle in China's Criminal Law that if the circumstances and consequences of an act are minor, then it is not a crime. But again that does not mean that you are subject to no sanctions at all. To take the most garden-variety example, different localities in China have a standard for the amount that one must steal in order to be considered a criminal, and it varies from place to place because of different levels of economic development. I don't know the exact numbers, but for example in Beijing it might be that if you steal property worth more than ¥1,000

that's considered a crime. If you steal between ¥500 and ¥1,000 then you're subject to Reeducation Through Labor. If you steal less than ¥500, then you're subject to Security Administration Penalties.

In our system, we have a distinction between felonies and misdemeanors, but they're all considered crimes and they're all dealt with through the formal criminal justice system. There are some differences in procedures, but the same fundamental rights are applicable in both cases. Whereas in China, a very important consequence of this distinction between crimes and illegal acts is that if you are subject to Reeducation Through Labor or Security Administration Penalties you are dealt with through an entirely different set of procedures and have different rights, generally fewer, than in the criminal justice system.

DD: Do these differences with the U.S. experience primarily reflect differences between China's reliance on a code rather than case system of law?

JH: It's a result of many things. Part of it again is a well-intentioned desire not to have the criminal justice system extend too broadly. In the eyes of people in China who think this is a good approach, the idea that stealing one dollar is a crime seems too harsh. So in a sense this is a manifestation of leniency.

But it can also be extremely inhumane, because of the lack of procedural rights for people who are put into this administrative system, and also because, being administrative, it's subject to a huge amount of discretion and potential abuse. And in practice, things have become very irrational. In some instances, if you have stolen ¥1,001, and you are put through the criminal justice system, though you'll have a criminal record, your prison term might be minimal or none. Whereas if you've stolen ¥999, you might spend three or four years in a Reeducation Through Labor camp. And of course the police have broad discretion to say whether you stole ¥1,001 or ¥999, and if they feel that they don't have the evidence to make a strong case that you've stolen ¥1,001, then they'll simply declare that you've stolen ¥999 and take care of the matter themselves through Reeducation Through Labor.

DD: You are one of the foremost experts in the U.S. on the Chinese practice of "Reeducation Through Labor." Could you tell us if changes in this practice have in any way affected China's efforts to slow the spread of HIV/AIDS?

JH: This is something that I've been thinking about a lot and have spoken about with people in China, because the number of cases involving Reeducation Through Labor and other forms of administrative penalties used specifically for

prostitutes, people who solicit prostitutes, and drug users, has skyrocketed in recent years. It may be that there is simply more of these types of behavior. It may be that the government and the police have decided that they are going to pay more attention to those offenses, completely apart from HIV/AIDS. Or it could be that they are concerned about the rapid spread of HIV/AIDS and they see this as a control measure whereby these high-risk populations will be rounded up. Then once they have been put into Reeducation Through Labor camps or "Custody and Education" camps for prostitutes or "Compulsory Treatment" centers for drug users, then they will be subjected to mandatory testing for HIV/AIDS and therefore can—in theory—be treated. There are many questions about the extent to which treatment is actually available for these people, which complicates the assessment of whether these sorts of measures are really being used to control the spread of HIV/AIDS. But I think it's likely that the connection has been drawn, though I can't say that with certainty.

DD: Is homosexuality also illegal but not a crime?

JH: It's not a crime. There are documents, and I assume they're still valid, that apply Reeducation Through Labor to homosexuality. I don't know to what extent they're enforced, but there's certainly the potential there.

This is related to the question of administrative sanctions and their impact on harm reduction. Regardless of why more people in high-risk groups are being subjected to administrative sanctions, I think that most people would say it's not a good thing, that it will lead to fewer people in these groups being willing to come forward for testing and treatment. I have a feeling that the reality in China is somewhat more complicated. The relationship, for example, between the police and prostitution is very complicated and I'm not sure that the fact that larger numbers of drug users and prostitutes have been subjected to these sanctions necessarily means that it's difficult for them to seek testing and treatment voluntarily. There are probably ways that people can go to the health system anonymously or under a false name. I'm not sure that health professionals feel that they have to report them. So I'm not sure that increased use of these administrative sanctions necessarily means that people are being driven underground.

But even if the rules against homosexuality are not enforced all the time, even if health workers are not always reporting when prostitutes or drug users come to them voluntarily for testing, the fact that this is part of the legal culture, part of the official attitude towards these sorts of behavior, seems likely to discourage people from coming forward.

DD: Can I pick up on one of the points that you made about the blameless victims, those who've received their infection through the blood donation system? Do you see any sign that this group will be able to find legal recourse?

JH: For these people, the issues are compensation, their need for health care, and nondiscrimination in work, education, and so forth. There are signs that these people are thinking more and more in terms of using the legal system to try to address these issues. But a major problem has been first of all making them aware of their legal rights and aware that this is a channel they can pursue. This is where efforts to develop legal services are so important. In the absence of a bureaucracy that serves their interests or that is supposed to speak for them, the question of how these people are going to find a voice is very, very important. The legal system may have to take on a bigger role for these people because they don't have a bureaucratic voice and they can't count on the women's federation or the youth federation intervening for them through bureaucratic channels. In that sense, they have to have recourse to the formal legal system. But on the other hand, particularly with respect to HIV/AIDS contracted through blood selling, there's so much local government interest wrapped up in those cases that it makes it very difficult as a practical matter to pursue them.

DD: How do you think the recent SARS outbreak will affect response to HIV/AIDS patients, and in particular those who were infected from blood collection stations overseen by local governments?

JH: In the short run at least, I think the overall political environment is going to be more encouraging of people raising questions about accountability and promoting openness in public health. And there are currently incentives for people in the political system to be responsive. However, I'm not sure that the lesson to government officials from SARS is necessarily to support people with HIV/AIDS coming forward with their complaints and concerns. I think that the general environment may be supportive, but from bureaucrats' perspective the main message from SARS is that you'd better do a good job of controlling disease. Of course, another lesson from SARS is that you really can't cover up public health problems. But if the emphasis is on being effective in controlling disease, that may justify all sorts of approaches. It doesn't necessarily point to any particular way of controlling disease, including HIV/AIDS.

DD: I know you've spent many years studying the evolution of the Chinese legal system and judicial procedure. What do you see as some of the most promising

trends at the moment, particularly as they may affect the trajectory of the HIV/AIDS epidemic?

JH: Coming back to the idea of nondiscrimination, I think that there's now potential in China to develop such an idea in the legal sense. In our legal system, anti-discrimination law has to a large extent been an element of tort law. Tort law in China has been developing fairly rapidly in some areas, such as product liability, but some basic ideas about fault, liability, calculation of damages, etc. remain relatively underdeveloped. These have direct relevance to issues of discrimination. My sense is that there is a lot at work on the Chinese scene today—rapid social change, the increasingly variegated circumstances that people live in, their experience of discrimination, greater opportunities for discrimination, people looking unsuccessfully for help through the traditional institutions and procedures, and tort law developments in other areas—that may come together to stimulate the development of discrimination law in a way that gives general ideas about nondiscrimination for people with HIV/AIDS some vitality. In fact, the National People's Congress is currently drafting the tort law portion of a continental-style Civil Code. This work is still in its early stages, but it could present an opportunity to give more attention to discrimination as an element of tort law.

Postscript on SARS

Ann B. Williams

Immediately following the conference during which many of the papers in this volume were first presented, the unexpected appearance of yet another lethal infectious disease threw a spotlight onto China's public health system. As a result of the ensuing economic repercussions, Severe Acute Respiratory Syndrome (SARS) commanded official attention to an extent that has eluded the AIDS epidemic for a decade. By June of 2003, Chinese media were reporting that, under Communist Party leadership, China had conquered SARS.

As the SARS epidemic unfolded, international health activists hoped the experience would serve as a wake-up call; that lessons about the value of openness and sound epidemiologic fieldwork learned from the SARS near-disaster would be used to craft a new, enlightened response to China's rapidly escalating AIDS epidemic. And, indeed, there are those in China who say, essentially, "In the past we neglected AIDS. But, we have learned from SARS and now will apply these lessons to AIDS."

But what, exactly, are the lessons of SARS and will they contribute to a rational and effective AIDS policy? There are reasons to be concerned.

The first concern is the assumption that a massive propaganda effort enlisting every Chinese citizen in a "People's War" against SARS was an effective and appropriate public health strategy. Public health education is essential, and China's propaganda machine is the envy of many other governments. But, war metaphors are very dangerous when applied to health problems. When a public health emergency becomes a war, all too often patients become the enemy. The patient-as-enemy approach is particularly tempting when most who suffer are poor, powerless, or perceived by others as immoral.

The second concern is the depiction of nurses and doctors as "angels and warriors in white clothes," prepared to "embrace death at any time." Of course there are risks associated with health care work, but they are not anywhere near as great as those found on the battlefield. Further, these risks can be greatly reduced, even in resource-constrained health care systems. In the case of SARS, "white-clothed angels and warriors" fell ill because of poor infection controls, lack of information, and misguided attempts to conceal a growing epidemic. If the risks are not reduced and if providing patient care is associated with acquiring lethal infections, workers may well choose not to care for people they deem undeserving of this sacrifice.

The third concern is the potential for "the people's surveillance" that emerged in the form of intrusive village and neighborhood monitoring committees to drive those with real disease risk underground and away from care. Particularly in the case of AIDS, the stigma associated with illness is so profound that in most of world patients closely guard information about their health risks and status. The resurrection of tactics last used during the Cultural Revolution, which decimated China's health care workforce, is ironic.

A fourth concern is whether the promise of free treatment for anyone suffering from SARS will be extended to those with AIDS. In the absence of technologically advanced medical equipment, treatment for SARS is supportive, inexpensive, and time limited. In contrast, AIDS care is life-long and, although certainly within the capacity of the Chinese health care professionals, requires substantial investment in the public and primary health care infrastructure. Tuberculosis care, while theoretically available, has not yet been delivered to most of the 400 million infected Chinese or even the 5 million with active disease.

It is arrogant to assume China needed the SARS experience in order to learn what to do about AIDS. The skeleton of an effective AIDS program already exists and there are many concerned and competent individuals deeply engaged in this work. The hope was that perhaps SARS would call the attention of those in the highest echelons of power to the serious implications of the deterioration of the public health care system.

The real lesson of SARS is meant for all of us and it is that, at the beginning of the twenty-first century, the world's governments can move with alacrity when the global economy appears threatened. Ameliorating the suffering of the millions at the margins of that economy is a different story.

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